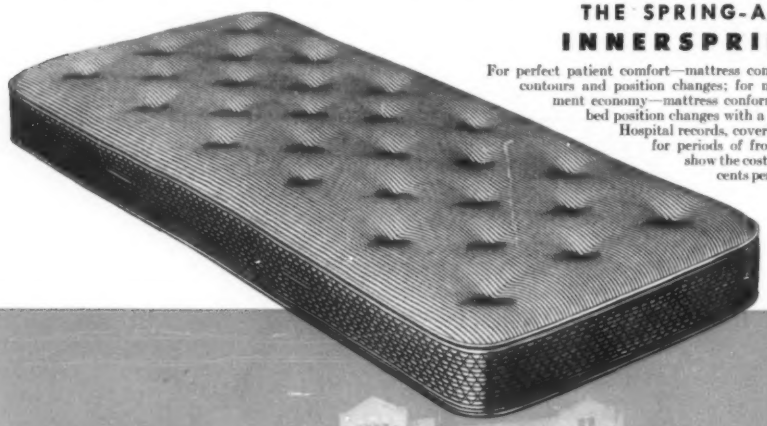
The Modern Hospital

JANUARY 1951

Hospital supplies and the national defense effort • Organization of nursing services • How to collect slow accounts • Round table discussion on fire safety • Trends in rates and charges • Recovery room • Moisture control

USED IN OVER 2000 GOOD HOSPITALS



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THE SPRING-AIR SLEEP CUSHION

Easy to handle, easy to keep clean ...and superbly comfortable—the Sleep Cushion consists of *separate* spring and pad units. Pad (cushion) is of compartment design, filled with long fibre cotton felt. Complete mattress almost fluid in conformance to bed and body position changes!

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Please send literature on hospital mattresses and name of Spring-Air plant in this area.

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The Modern Hospital

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AMONG THE AUTHORS


Dr. E. R. Weinerman

Dr. E. Richard Weinerman is associate professor of medical economics in the school of public health at the University of California and head of the division of medical care administration. He was trained at Yale, Georgetown and Harvard universities, originally in internal medicine and subsequently in public health and medical administration. Dr. Weinerman was assistant medical director of the Farm Security Administration Rural Health Program and later served as consultant in medical care administration to the U. S. Public Health Service. Closely associated with the curriculum in hospital administration, his program at the University of California is designed as an experiment in preparing qualified personnel to plan and operate medical care programs. The article on page 77 comparing hospital charges with economic trends in prices and wages is illustrative of his research activities in the social and economic aspects of medicine.


Cecil Gronvall

Cecil Gronvall, who collaborated with Dr. Weinerman in the article on hospital charges, approaches the subject with a background as a teacher, supervisor and administrator of research and training programs in local, state and federal agencies. Immediately before beginning his work for an M.P.H. degree in medical administration in 1947, he spent five years with the Office of Price Administration, finally as training specialist for the San Francisco regional office. Here he administered programs for five western states in orientation and basic job supervision and management training.


George Blumenauer

A native of New York State, **George Blumenauer** moved to the Southwest several years ago, and today he is carrying on his work as hospital planning consultant and architect in Little Rock, Ark. With Paul E. Fesler, he developed one of the prize-winning plans in The MODERN HOSPITAL's small hospital competition several years ago. He has made a number of studies of rural health care problems in the Southwest and has written extensively for hospital journals. His article on moisture control in the hospital appears on page 114 of this issue.


David E. Olsson

David E. Olsson, whose article in this issue (page 53) deals with the familiar problem of accounts receivable, is the assistant administrator of San Jose Hospital at San Jose, Calif. After getting his B.S. degree at St. Mary's College, Calif., Mr. Olsson worked for a year with a major oil company and then spent six years in the U.S. Air Corps. After the war, an interim period of 18 months before he enrolled in the University of Minnesota's course in hospital administration gave him experience in handling patients' accounts. As administrative assistant in the Contra Costa, Calif., county welfare department, he was, among other things, responsible for collection of overdue accounts. In addition to the business side of hospital administration, Mr. Olsson is interested in public relations, and he has been active in civic affairs. The hospital which takes the community into its confidence, he believes, will not be lacking support when the chips are down and the bills presented.

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Roving Reporter

Lesson From India

How to operate a 90 bed hospital on an annual budget of $33,000 was part of the astonishing story told by Dr. Norma Farmer of Kolhapur, India, on a recent visit to the United States. But Dr. Farmer, who is surgeon in charge of the Mary Wanless Hospital at Kolhapur, had an even more important message for U. S. hospital administrators. "Through wisdom is a house builded," she said, quoting the 24th chapter of Proverbs, "and by understanding it is established: And by knowledge shall the chambers be filled with all precious and pleasant riches."

Mary Wanless Hospital at Kohlapur. Two doctors and the superintendent of nurses discuss the care of the patient who has just arrived at the hospital by ambulance.

Dr. Farmer thinks of the Mary Wanless Hospital as such a house, built on wisdom and filled with understanding love as well as knowledge. "We are a family," she says, speaking of the hospital's staff and patients, "and our authority comes from the inside. Our people do honest, hard work happily—because they *care*."

Dr. Farmer has been in charge of the Wanless Hospital, which is maintained by the Presbyterian Church, for the last 20 years. During that period it has grown from 37 to 90 beds—not, however, by the customary American method of new construction, but simply by putting two rows of beds where one had been before, and then three instead of two, and by using every inch of space in the one-story stone hospital buildings. Most of the patients are in two large wards—one for men and one for women—but there are a dozen private rooms, and for patients who wish to pay for added privacy or for those whose illness requires special care, the doctors' bungalow is often used as a reserve. Surgical, medical and obstetrical cases are about equally divided, and the hospital has about equal numbers of men, women and children patients. A large percentage of the population of the district of Kolhapur, with its ancient capital city of 100,000, suffers from avitaminosis and other nutritional deficiencies. These conditions, plus infections, give rise to intestinal disorders requiring surgery, which is done by Dr. Farmer and the three Indian physicians on the hospital staff. In a clinic near the hospital, Dr. Farmer and her associates see from 60 to 100 patients a day. "We are making some progress against the malnutrition," she reported. "The problem is less severe than it was when I first came, because we now have specific remedies, just as we do for the lepers in the leper clinic." But, she added, there is always a vast reservoir of unmet needs. "The more Indians are given for good medical care, the more good care is needed and de-

manded," she said. "The hospitals are full all the time."

According to medical observers from America, the Wanless Hospital has first-rate professional standards, with infection and mortality rates that compare favorably with those in institutions having many times its resources. One reason this record can be achieved, of course, is the generosity of the church, which, in addition to the senior staff of skilled and devoted workers, provides modern equipment for the surgical and obstetrical departments. Another reason Dr. Farmer can give modern hospital care at a cost of only a little more than $1 a patient day (one-tenth to one-twentieth of U.S. hospital costs today) is that the hospital gets lots of help from the patient's family in nursing and housekeeping routines and is almost entirely relieved of responsibility for food service.

"Usually someone from the patient's family moves right in with him," Dr. Farmer said, describing how the system works. "We provide the cooking facilities and a few utensils, and they bring and prepare the food, and serve it to the patients."

Some patients arrive at the dispensary in vehicles like this—a cradle made into a palanquin, with boards, ropes and pole.

Still others come in ox-drawn carts.

There is also a very modern ambulance.

Thinking of how hospital administrators in the United States complain bitterly about "the visitor problem," a friend asked Dr. Farmer if these Indian families weren't difficult to manage. "Not usually," she replied. "Members of the family come and go as they wish,

and are most cooperative. They do exactly as they're told in matters concerning the patient's care. In fact, they couldn't be more helpful!"

In spite of this virtually uncontrolled traffic in and out of the hospital's wards, and the close proximity of beds to one another in the wards, there is very little cross-infection, Dr. Farmer reported. "We do the best we can, taking the situation as we have it and looking always toward the ideal," she said. Difficult as many of the conditions in India today may seem, they do represent an improvement over the circumstances she encountered 20 years ago. Dr. Farmer recalls that in the villages she used to do cataract operations in open courtyards, often with oxen tethered across the court a few feet away. Now, more work is being done in hospitals, though the need in the villages is still a tremendous one.

Patients at the clinic and hospital are asked to pay something if they can, though many are cared for entirely free. "We find it better if people are made to pay a little," Dr. Farmer said. "This makes them value the care they receive more highly, and they are likely to be more regular and conscientious about coming back for follow-up treatments."

In addition to her physician assistants, Dr. Farmer has an American superintendent of nurses and nurse-business manager, a small staff of nurses trained at near-by Indian schools, and a group of male and female ward helpers—all Christians, though patients of all faiths and castes are treated in the same way, and no effort is made to force religious teaching.

Tumors sometimes grow large before patients come to seek help from the hospital.

However, religious faith, as Dr. Farmer explains it, is the foundation of the hospital's service. She told about an advanced diabetic patient who stayed on at the hospital following amputation of one leg and seemed reluctant to leave, even after he had been given all the care and assistance he required. Finally, Dr. Farmer asked him why he didn't go home.

"Here I have seen love," the man answered.

There are many lessons for American medical and hospital people in the work of Dr. Farmer and other medical missionaries abroad, but unquestionably this is the greatest lesson. "We keep remembering that the hospital is there not for *patients* but for each *individual patient*," Dr. Farmer concluded. "The work in a hospital offers a chance to invest one's life in as effective and satisfying a way as anybody could wish for. A by-product of that investment is happiness."

They Made the Hospital Tick

No. 9, in its series of annual reports, was a magic number for Hillcrest Memorial Hospital, Tulsa, Okla. Somebody had the choice idea of building an annual report around the people who make the hospital tick. Maybe the idea came from the public relations information committee of the board of trustees; at any rate that committee acts as the reader's guide through department after hospital department.

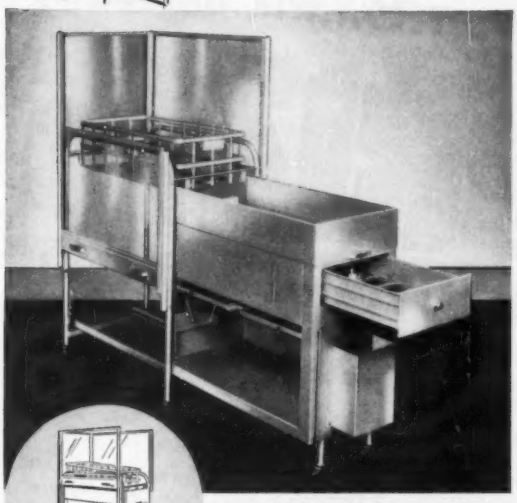
The frontispiece of the printed report is a sketch of a hospital bed captioned "What supports a hospital bed?" A better pronoun would be "Who," for the entire emphasis is on persons and personalities starting out with the individual trustees, followed by board and auxiliary committee chairmen, medical advisers to the board, medical staff officers and committees, personnel director, controller, purchasing agent, directors of nurses and school, instructors and department heads.

Under pictures of department heads, for example, are brief reports of their year's load of work. The rest of the 32 page book shows dozens of action shots about the hospital—three beautiful nurses in evening dress, with caption emphasis on their sincerity and intelligence along with their good looks; close-up of a doctor dictating a patient's record; the chaplain reading comforting words to a patient; a skeleton coming out of his closet for nurse instruction.

While to the quick observer it looks like a picture book, there is a surprising volume of factual material packed under or beside the photographs. On the final two pages are compact reports of Administrator Bryce Twitty and Board Chairman N. R. Graham.

Improved protection for the infant

SHIELDED BASSINETS WITH INDIVIDUAL DRESSING TABLES PROVIDE SAFEGUARDS AGAINST AIR-BORNE BACTERIA AND CROSS-INFECTION



CLOSED VIEW showing compact, space-saving design. Dressing table slides out to provide individual work space.

Above: **BERGMAN Glass-Sided BASSINET and DRESSING TABLE.** One glass side lowers to provide easy access to infant. Dressing table pulls out from narrow side. Drawer holds required utensils in removable tray. Storage compartment below with disappearing-type door. Entire unit made of finest enameled steel or stainless steel in welded, crevice-free construction.

Right: **MERCY Glass-Sided BASSINET and DRESSING TABLE.** Safety glass shields on three sides. Dressing table slides out. Specially-designed quarter-circle drawer swings out, holds necessary utensils. Large storage compartment below for sterile linen and other supplies; has disappearing-type door. Unit available in enameled steel or stainless steel.

IN guarding against infection of the newborn, hospitals are increasingly concerned with obtaining the latest and best type of equipment for nursery use. Blickman-Built Combination Bassinets and Dressing Tables are designed to assure safe nursery technics. Basic features of construction provide the following safeguards:

1. *CUBICLE-TYPE DESIGN* with safety glass panels on three sides – protects against airborne bacterial infection and impetigo.
2. *INDIVIDUAL DRESSING TABLE* assures asepsis, minimizes danger of contamination and epidemic diarrhea.

Other models of Blickman-Built Bassinets and Dressing Tables are available for specific hospital requirements. Write for further information.

WHEN CLOSED, the Mercy model provides a compact unit for cubicle use.

ROOMING-IN TECHNIC – Because of their mobility, the Bergman and Mercy models illustrated are highly recommended to hospitals using the Rooming-In method. The safety glass sides afford protection against air currents when bassinets are wheeled from adjacent nursery to mother's bedside. These units give cubicle protection to the infant while in the mother's room.

INQUIRIES INVITED . . . regarding your equipment problems. Room lay-outs, specifications and prices furnished without obligation on your part. Send for illustrated catalogs describing complete "Conqueror Line" of Hospital Equipment.

Send for NURSERY CATALOG NO. 11 NEC Illustrates and describes numerous models of bassinets as well as many other recent developments in nursery and pediatric equipment.

S. Blickman, Inc., 1501 Gregory Ave., Weehawken, N. J.
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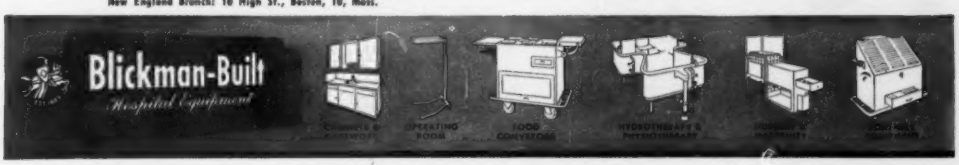



EMPLOYERS, EMPLOYEES...WIN ONE OF
60 PRIZES
IN 1951 GENERAL FOODS CONTEST!
2 complete sets of prizes
total 700,000 General Foods prize points!
2 FIRST PRIZES: First prize winner in each group gets all-expenses-paid trip for two people to the 1951 National Restaurant Association Convention in Chicago, Ill.—May 7 through May 11, 1951—consisting of railroad, air or bus fare, hotel for 5 days, tickets for all important official functions, and $200 spending money—or 100,000 prize points.
2 SECOND PRIZES:* Each second prize winner gets choice of Crosley 19-inch TV set; Crosley Console Radio and 3-speed Phonograph Combination; Crosley 10.53-cu.-ft. Shelvador® Refrigerator; or 75,000 prize points.
2 THIRD PRIZES:* Each third prize winner gets a choice of all-expenses-paid trip for one person to NRA Convention; complete man or woman's Kroydon Registered Golf Set; Gyramatic Bendix Washer; or 50,000 prize points.
2 FOURTH PRIZES:* Each fourth prize winner gets choice of 12-foot Penn Yan Cartop Boat with auto carry set; Wheary Luggage Set; White Sewing Machine; or 35,000 prize points.
2 FIFTH PRIZES: Each fifth prize winner gets 25,000 prize points.
Next 10 winners in the two groups each gets 5,000 prize points
Next 15 winners in the two groups each gets 1,000 prize points
*If, due to emergency conditions, any of these prizes is not available, a suitable substitution will be made.
EVERY ENTRY GETS A PRIZE! 85 prize points will be sent with the compliments of General Foods to everyone entering the contest!
General Foods prize points are packed with almost all G.F. institution products. You may redeem them for your choice of more than 1,400 prizes for business or personal use. Write for free catalog listing the more than 1,400 G.F. prizes to: General Foods Institution Prize Department, Box 121, Dayton, Ohio

GROUP 1

Open to owners, executives, dietitians, chefs, department heads and to *all* back-of-the-house employees!

You can win by writing statement of not more than 150 words on:

"What we do to reduce food costs without reducing quality."

(see complete contest rules below)

GROUP 2

Open to captains, waitresses, waiters, cashiers and *all* front-of-the-house employees!

You can win by writing a statement of not more than 150 words on:

"What we do to make customers come back to our eating place!"

(see complete contest rules below)

CONTEST RULES

1. Contest open to owners, executives or employees whose principal occupation is in connection with operation of restaurants, hotels, hospitals, industrial restaurants, or other public feeding places in the continental U. S., except employees of General Foods Corporation, its advertising agencies, and members of their immediate families.

2. Entries must concern the establishment with which you are associated. You may only enter group in which you are listed. Statement must be your own original work submitted in your own name.

3. Entries must be mailed to Reuben H. Donnelley Corp., P. O. Box 1360, New York 46, N. Y. and be postmarked not later than February 28, 1951. Entries with inadequate postage will not be considered.

4. Prizes, as listed elsewhere in this advertisement, will be awarded to contestants whose statements are considered the most sound and sincere in the opinion of the impartial judging staff of Reuben H. Donnelley Corp. Decision of the judges is final. Duplicate prizes will be awarded in case of ties.

5. Winners will be notified by mail. Their names will appear in the May issues of many Institution publications. Entries and statements become the property of General Foods Corporation to be used as it sees fit and will not be returned. Contest subject to all federal, state and local regulations.

ENTRY BLANK—Fill in entry blank or a facsimile and attach it to your statement.

Reuben H. Donnelley Corp.
P. O. Box 1360, New York 46, N. Y.

Please enter me in 1951 General Foods' 700,000 Prize Point Contest, in group indicated, for which I am eligible. (You may enter only one group.)

Group I ☐ I am submitting a statement of not more than 150 words on: "What we do to reduce food costs without reducing quality."

Group II ☐ I am submitting a statement of not more than 150 words on: "What we do to make customers come back to our eating place!"

My name_____ Title_____

Name of Establishment_____

Street_____

City_____ Zone_____

County_____ State_____

(code) (MH)

The Albany Hospital
in Albany, New York, achieved beauty and comfort for patients and staff by sound conditioning this corridor with Acousti-Celotex Ceiling Tile.

Beauty plus Quiet in a hospital corridor

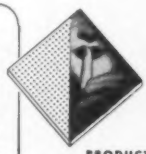
As long as people walk, there will be footsteps to hear. As long as meals are served, glasses will clink and dishes clatter. But these irritating sounds can and should be checked to benefit hospital patients and staff members.

Modern sound conditioning brings direct and *immediate* benefits to any busy hospital. Thousands of unavoidable, routine sounds are effectively muffled *before* they can create a steady, annoying din that disturbs patients and tires the staff.

Acousti-Celotex Ceiling Tile maintains quiet and comfort in busy hallways, wards, rooms and kitchens. Speeds patient recovery, too! Doctors, nurses and service personnel work more efficiently with less daily strain and fatigue.

This durable, lightweight acoustical tile has already brought quiet comfort and beauty to thousands of efficient hospitals. No special maintenance is required and you can paint or wash Acousti-Celotex tile repeatedly *without* impairing its sound absorbing efficiency!

FOR A FREE ANALYSIS of your particular noise problem, write now for the name of your local distributor of Acousti-Celotex products. He's an expert in modern sound conditioning techniques with the finest acoustical products ever developed. We will also send you a copy of an informative booklet entitled "The Quiet Hospital." The Celotex Corporation, Dept. G-1, Chicago 3, Ill. In Canada, Dominion Sound Equipments, Ltd., Montreal, Quebec.



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PRODUCTS FOR EVERY SOUND CONDITIONING PURPOSE

THE CELOTEX CORPORATION • CHICAGO 3, ILLINOIS

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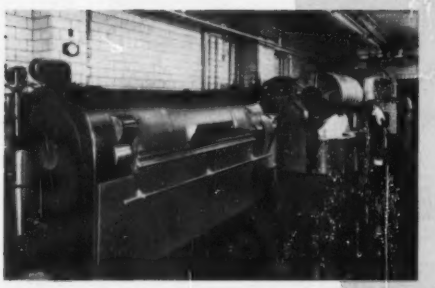
Saves ⅓ of former operating cost

WITH NEW AMERICAN-EQUIPPED LAUNDRY



Time and labor are saved at Mount Sinai Hospital with these 2 CASCADE Unloading Washers, and NOTRUX Extractor (shown beyond washers). Pressing buttons automatically unloads work from washers into NOTRUX Containers. Containers then travel by overhead rail to the Extractor where they are loaded and unloaded by electric hoist.

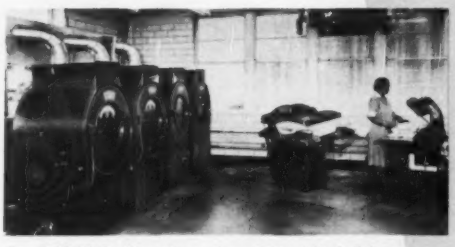
Since installation of their new "AMERICAN" equipped laundry, 410-bed Mount Sinai Hospital, Cleveland, O., has *saved ⅓ of their former operating cost.*

Our Laundry Advisor made an exhaustive study of the Hospital's clean linen needs. He then recommended laundry equipment of proper type and capacity, and submitted a floor plan of the laundry layout to insure maximum operating efficiency. As the result of his recommendations, Mount Sinai Hospital has benefitted in the following ways:

- ***Fewer operators needed***
- ***Shorter working hours***
- ***More efficient work flow***
- ***Faster return of linen to service***
- ***Smaller linen inventory required***
- ***Better quality work***

Our Laundry Advisor can help YOU make similar savings. His free services are available to hospitals, large or small, *without any obligation whatever.* WRITE TODAY.

Remember . . . *Every Department of Your Hospital Depends on the Laundry.*



Four ZONE-AIR Tumblers (shown above, left) quickly fluff-dry work requiring no ironing. NURSES' PRESS UNIT (at right) enables one operator to completely machine-iron garments in a simple, speedy sequence that saves time and motions.

Linens are beautifully ironed, at a high rate of speed, on this 8-Roll STREAMLINE Flatwork Ironer with AIRVENT Canopy. TRUMATIC Folder, at delivery end of Ironer, automatically quarter-folds large linens lengthwise, enabling only one receiving operator to handle entire output of ironer.

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LAUNDRY MACHINERY CO.

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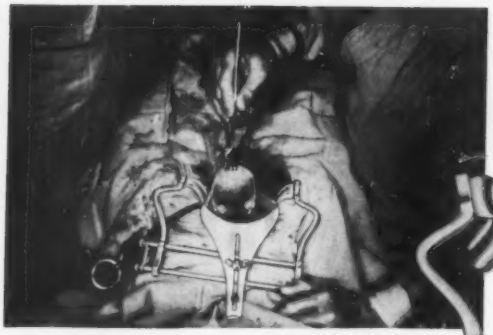

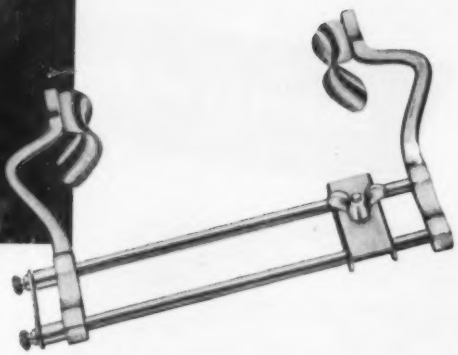

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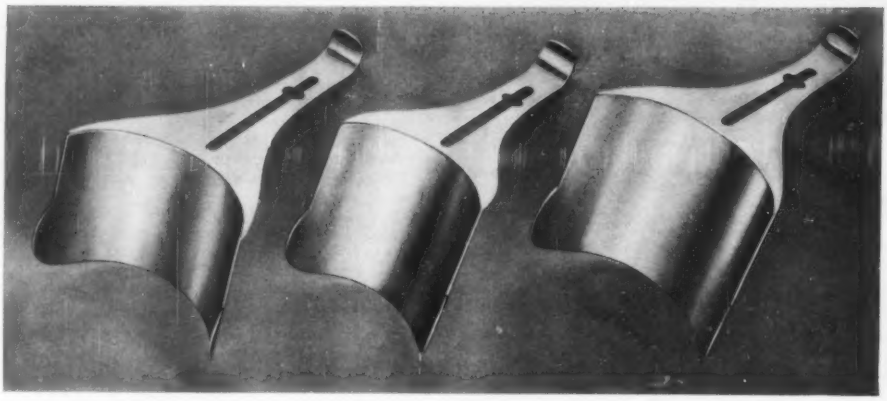

Introducing the new stainless-steel PURCELL SELF-RETAINING ABDOMINAL RETRACTOR, designed by Ernest F. Purcell, M.D., F.I.C.S., head of the department of gynecology and Senior Attending Gynecologist, McKinley Hospital, Trenton, N. J.

Adjustable, self-retaining, double-bar frame permits compensation for abdominal relaxation or further exploration; extra large blade, supplied in three sizes—4″ x 4″, 3½″ x 5″, 4″ x 5″—restrains the intestines from the operative field.

Ask your surgical dealer to show you the R-2039 PURCELL SELF-RETAINING ABDOMINAL RETRACTOR . . . another precision-made instrument introduced by the

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Bringer of glad tidings
Builder of goodwill

Here is a brand new idea in community goodwill building – an appreciated service to patients – *that actually pays direct cash profits to your hospital.*

The plan is very simple—just provide *Certific-ettes* for every maternity patient.

Certific-ettes are *custom-made* birth announcement cards created especially for your individual hospital and available *only* through your hospital.

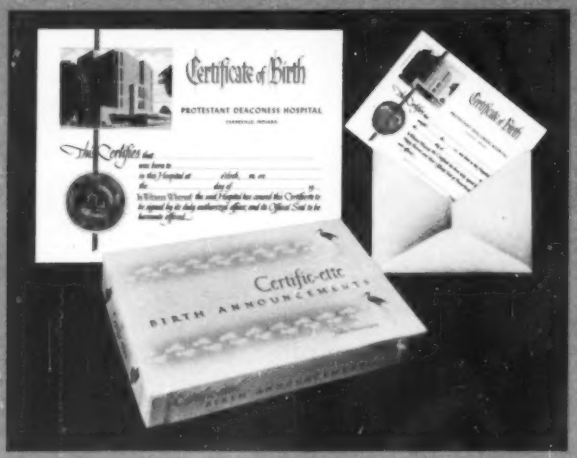
Certific-ettes are beautifully simple, refreshingly different and completely individual. Excepting changes in wording, they are lovely, *miniature reproductions* of your hospital birth certificate —just like the one you present to happy new mothers and fathers.

Certific-ettes are so reasonably priced that parents are sure to send them throughout the community you serve.

For details on how your hospital can "put parents to work" in this goodwill program, and at the same time secure a steady, day-to-day income, turn this page.

Hollister Hallmark Quality

Here is the Custom-Made Birth Announcement that will earn extra dollars for your hospital



Hollister Heirloom Quality

These new, clever birth announcements — eagerly purchased by parents to announce the birth of their baby — are one of today's "best buys" for parents and hospitals alike.

Exclusively yours — never sold in stores — they are filled in and signed by the happy parents and sent to friends and relatives — "advertising" your hospital, creating friendly comment wherever they are received.

Illustrated maternity booklets . . . full of interesting information for mothers-to-be . . . are furnished free of charge with every order for Certific-ettes. Presented as a gift to every maternity patient — these booklets are — in themselves — effective goodwill builders.

An ideal project for Women's Auxiliaries, the sale of Certific-ettes offers unusually fine opportunities for building goodwill with patients. Then, too, the profit possibilities are exceptional — 300 boxes of Certific-ettes provides a profit of over $400.00!

For further information on how you may obtain Certific-ettes for your hospital, tear off the coupon below and mail it today. No obligation, of course.

We're interested in Certific-ettes for our hospital.
Please send the following immediately:

1. Actual matching samples of Hollister *Inscribed* Birth Certificates and Certific-ettes.
2. Price list showing profit earnings.
3. Literature describing Hollister *Inscribed* Birth Certificates and Certific-ettes.

FRANKLIN C. HOLLISTER CO.
833 North Orleans Street, Chicago 10, Illinois

ADMINISTRATOR

HOSPITAL

STREET

CITY ZONE STATE

INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—28th Edition

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Save Money

by using the right tape for the right job!

SAVE 40¢, 45¢, 50¢ OR MORE A ROLL WITH NEW

SEAMLESS *service weight* PRO-CAP

Here is a wonderful new lightweight adhesive plaster that can stretch your hard-pressed budget . . . slash your supply expenses—Seamless SERVICE WEIGHT Pro-Cap.

Here is an adhesive plaster *specially made* for those taping jobs that do not require the support of a heavyweight tape. And, because we are able to use a lighter textile fabric, we can pass along big savings to you. This fine new tape meets U.S.P. specifications.

Little or No Skin Irritation

Seamless SERVICE WEIGHT Pro-Cap contains the same exclusive *adhesive mass*—incorporating fatty acid salts—that has made REGULAR Pro-Cap such an outstanding success. Independent clinical tests prove Pro-Cap causes little or no skin irritation, minimizes itching, sticks better, leaves almost no slimy deposit.

Order Seamless SERVICE WEIGHT Pro-Cap today through your Hospital or Surgical Supply Dealer. *Use the right tape for the right job—and save money!*

For Strong Support—REGULAR Pro-Cap in the brown and buff tube. For bandaging, taping and strapping those portions of the body and limbs that require the strong support of a heavyweight tape with high tensile strength.

For Light Taping Jobs—SERVICE WEIGHT Pro-Cap in the blue and white tube. Ideal for bandaging and taping where strongest support is not necessary. The lighter fabric means extra patient comfort, too.

FINEST QUALITY SINCE 1877

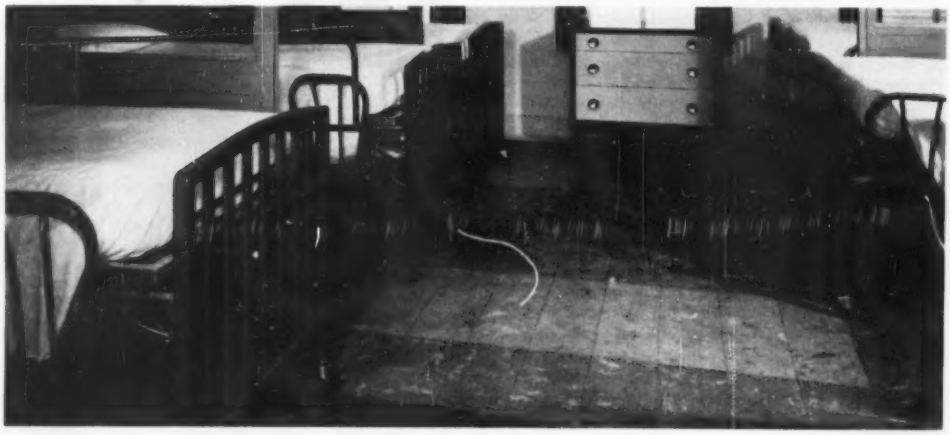
In the New Blue and White Tube

SURGICAL DRESSINGS DIVISION
THE SEAMLESS RUBBER COMPANY
NEW HAVEN 3, CONN., U. S. A.

SR SEAMLESS

↑ **Armstrong's Rubber Tile** is a flooring well chosen for busy areas such as this exercise-recreation room. Unusual durability and resistance to indentation enable it to withstand hard use. It is exceptionally resilient. It is now possible to install Armstrong's Rubber Tile over on-grade concrete subfloors, when installed with Armstrong's No. S-104 Chemical-Set Waterproof Cement.

↓ **Armstrong's Asphalt Tile** is an attractive, low-cost flooring suitable for hospital bedrooms, wards, and other areas throughout the hospital. It is a tough, long-wearing floor that is easy to maintain. Because it is not affected by alkaline moisture, this floor can be installed on concrete subfloors in direct contact with the ground. Made in two service types—Standard and Greaseproof.



There's an Armstrong Floor for every hospital need

BECAUSE the rooms throughout a hospital are put to many different uses, the floors must meet varying requirements. Where extra heavy wear must be considered, Armstrong's Rubber Tile or Linotile® give the most for the money since their extra service outweighs their higher initial cost. Where economy is important, Armstrong's Asphalt Tile is recommended. This low-cost flooring can be used effectively over any type subfloor and is particularly recommended for basement floors because of its resistance to alkaline moisture. Most suspended flooring needs can be met with Armstrong's Linoleum since it combines durability, ease of maintenance, and moderate cost. Your Armstrong contractor will be glad to help you select the proper Armstrong Floors for each hospital area.

GET ALL THE FACTS—Send for free 20-page booklet—"Which Floor for Your Business?" This booklet in full color gives you the facts about all the Armstrong Resilient Floors for hospital and institutional uses. It also illustrates many floor design suggestions which may help you in your floor planning. Write Armstrong Cork Co., Floor Division, 5701 State St., Lancaster, Pa.

Counter with seamless sinks, wall cabinets and base cabinets—all in welded and polished Stainless Steel—in Utility Room at Walter Reed Hospital. Equipment was fabricated by Atlantic Alloy Industries, Inc., Newark, N. J.

More Stainless Steel equipment fabricated by Atlantic Alloy for Walter Reed Hospital. This supply cabinet and knee-operated surgeon's scrub sink are located in a Minor Surgery Room.

Work area in Dermatology Section of Out-Patient Department at Walter Reed Hospital has cantilever-supported Stainless Steel counters and built-in Stainless Steel overhead cabinets by Atlantic Alloy.

In the out-patient service of Walter Reed Hospital *Stainless* equipment is standard equipment

Stainless Steel's special fitness for hospital service has been utilized fully in this new addition to Walter Reed Hospital, Washington, D. C. Like so many other hospital officials, administrators at this big Army medical center have found that no other material meets their exacting requirements quite as well as Stainless Steel.

Stainless has proved itself to be unsurpassed for equipment where even the slightest contamination cannot be tolerated . . . it's an aid in maintaining asepsis at all times. And because it is so easy to clean and keep clean, it saves much time-consuming labor and drudgery for busy hospital personnel.

This tough, strong, corrosion-resisting material is unsurpassed, too, for withstanding the hard knocks and everyday wear of hospital service. It stays like new year after year. And its attractive, shining surface is a real morale-booster for patients . . . they *know* everything possible is being done for their protection.

For Stainless equipment at its best, make sure that your fabricator uses U·S·S Stainless Steel. Hundreds of hospitals are using this perfected, service-tested material—add yours to the list.

AMERICAN STEEL & WIRE COMPANY, CLEVELAND · COLUMBIA STEEL COMPANY, SAN FRANCISCO
NATIONAL TUBE COMPANY, PITTSBURGH · TENNESSEE COAL, IRON & RAILROAD COMPANY, BIRMINGHAM · UNITED STATES STEEL COMPANY, PITTSBURGH
UNITED STATES STEEL SUPPLY COMPANY, WAREHOUSE DISTRIBUTORS, COAST-TO-COAST · UNITED STATES STEEL EXPORT COMPANY, NEW YORK

USS

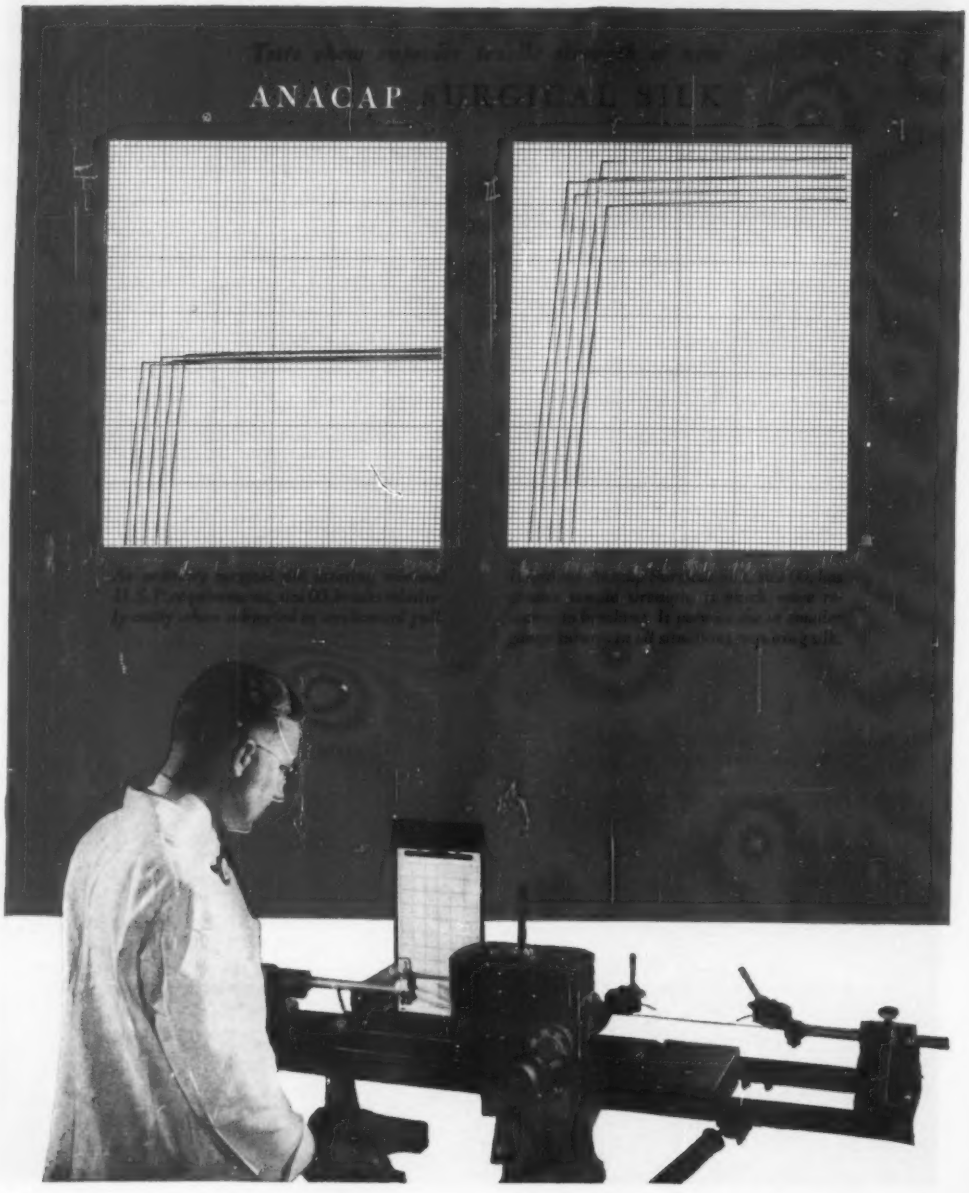
U·S·S STAINLESS STEEL

SHEETS · STRIP · PLATES · BARS · BILLETS · PIPE · TUBES · WIRE · SPECIAL SECTIONS

T-120

UNITED STATES STEEL

AN ADVANCE IN SURGICAL SILK



New improved ANACAP®
SURGICAL SILK

Greater tensile strength: New improved Anacap Surgical Silk, one of the strongest silk sutures ever developed, allows the use of smaller diameters. Trauma and tissue reaction are minimized.

Withstands repeated sterilization: Anacap surgical silk can be boiled or autoclaved repeatedly without clinically significant loss of strength. In laboratory tests almost the full original strength is maintained even after twenty-three and one half hours of boiling.

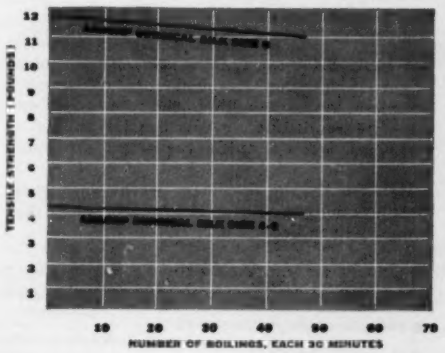
Absolute non-capillarity: No wick-like action, Anacap Silk resists bacterial invasion and withstands effects of body fluids and moisture.

Easier to handle: Anacap Surgical silk is firm. It does not become limp when moist. It retains flexibility and pliability resembling that of fine surgical gut.

Economical: Because Anacap Silk sutures may safely be sterilized at least six separate times in the operating room, or *twice* as often as many other silks, they are economical to use.

Anacap Surgical Silk is available on spools of 25 and 100 yards in sizes 6-0 to 5, and in sterile tubes with and without D & G Atraumatic® needles attached.

Effect of repeated boilings on tensile strength of Anacap Surgical Silk. For example size 0 with initial tensile strength of 12 pounds has been boiled 47 separate times (total 23½ hours); sizes 4-0 with an initial tensile strength of 4.5 pounds was also boiled 47 times. Despite repeated sterilization, tensile strengths remain far in excess of U.S.P. requirements. New Anacap Surgical Silk can be sterilized twice as often as many other silk sutures.



DAVIS & GECK, INC.

57 Willoughby Street, *Brooklyn 1, N.Y.*

HOSPITALS ARE VITALLY CONCERNED with AIR INFILTRATION Through Windows

Laboratory Testing Gives You The Facts on...

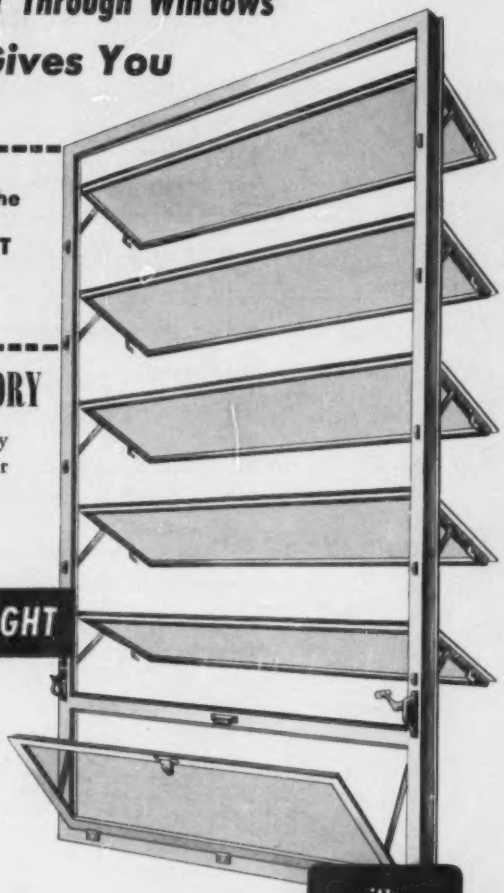
Auto-Lok PATENTED weatherstripped ALUMINUM AWNING WINDOWS

Here is the REPORT of the

PITTSBURGH TESTING LABORATORY

The report states simply and convincingly that our **AUTO-LOK** Window showed air infiltration of only

"0.095 cfm per foot at a static pressure equivalent to 25 mph."



A CLOSURE TEN TIMES AS TIGHT

A rate of air infiltration of only 0.095 cfm is *amazingly* low. It is the equivalent of a closure at least *ten* times as tight as the generally accepted requirements for casement and projected windows.

AT LAST! *Year 'round patient comfort.* Auto-Lok's tight closure eliminates dangerous "cold spots" common to most windows...and when you want it, 100% ventilation...even when it's raining... with just a few simple turns of the operator.

AUTO-LOK, the all-climate awning window, is fast becoming the first choice with hospitals the country over, because it:

- reduces air infiltration to a minimum.
- reduces maintenance costs.
- slashes fuel bills.
- makes air conditioning more economical.
- provides positive protection against all climatic extremes.
- assures draft-free ventilation...even when it's raining.
- can be cleaned entirely from the inside.

For the comfort of patients, consider Auto-Lok. We shall be glad to furnish names of other hospitals which warmly endorse this proven product. Our engineering department is at all times at your disposal to assist in window planning.

it's sealed like a refrigerator

Write for nearest distributor's address and for free folder, "What Is Important In A Window?" address Dept. MH-1

LUDMAN CORPORATION

P. O. Box 4541 Miami, Florida

DUST IS EXPENSIVE

UNCONTROLLED DUST that 'gets by' old-fashioned floor care . . . *spreads* air-borne bacteria that may cause absenteeism . . . *redeposits* itself in bins, shelves, finished products where it must be removed again . . . *tracks* into clean areas and makes floor surfaces unsightly and insanitary!

WESTONE CONTROLS DUST. Inexpensively. It's an antiseptic floor treatment. Inhibits the growth of certain bacteria right at the source. Loosens and picks-up all dust. Seals surfaces. Holds subsequent dust down for quick, easy removal. Keeps bins clean. Speeds materials handling. Reduces floor maintenance costs up to 50%. As a WEST representative can easily demonstrate. Without charge.

WESTONE an antiseptic *DUST CONTROL* floor treatment.

WEST DISINFECTING Company

Show me how to save money by controlling floor dust

West Disinfecting Company, 42-16 West Street, Long Island City 1, New York
(44 Branches in the U. S. and Canada)

Gentlemen: I'd like to have a local WEST representative come out and give me a demonstration of Antiseptic WESTONE dust control. On this date_____

Mr._____ Position_____

Company_____

Address_____

City_____ Zone____ State_____

12

Literature and directions for administration of ACTHAR, including contraindications, are available on request.

ACTHAR is supplied in 10, 15, 25, 40 and 50 mg. vials, in packages of 10, 25 and 50 vials.

. . . hours

Reversal of heretofore intractable diseases beginning within hours after instituting ACTHAR therapy, is the culmination of years of intensive research by The Armour Laboratories, together with independent investigators.

✔ ACTHAR, the first adrenocorticotropic hormone made available to the physician, represents the physiologic stimulus for the adrenals to produce and discharge the complete spectrum of cortical hormones.

Virtual absence of cumulative effects permits precise, yet flexible, dosage schedules. The exclusive utilization of physiologic mechanisms for its powerful therapeutic action furthermore contributes to the clinical safety of ACTHAR.

ESTABLISHED INDICATIONS: Collagen diseases or connective tissue diseases, such as rheumatoid arthritis, rheumatic fever, acute lupus erythematosus; hypersensitivities, such as severe asthma, drug sensitivities, contact dermatitis; most acute inflammatory diseases of the eye; acute inflammatory conditions of the skin, such as acute pemphigus and exfoliative dermatitis; inflammatory conditions of the intestinal mucosa, such as ulcerative colitis; and metabolic diseases, such as acute gouty arthritis and secondary adrenal cortical hypofunction.

ACTHAR

ARMOUR LABORATORIES BRAND OF ADRENOCORTICOTROPIC HORMONE (A.C.T.H.)

THE ARMOUR LABORATORIES

CHICAGO 11, ILLINOIS

PHYSIOLOGIC THERAPEUTICS THROUGH BIOCHEMICAL RESEARCH

Hospital Credits Modern GAS Kitchen...

Queen of Angels Hospital, Los Angeles. Sister Mary Raymond, Mother Superior

Gas ranges and broiler in island arrangement

FOR *SMOOTH-RUNNING* FOOD SERVICE

Gas-fired steam cooker and kettles

Gas-fired steam tables, coffee urns and toaster in service section

EASE OF OPERATION of the modern Gas Equipment is a major factor in the efficiency of the food service system at Queen of Angels Hospital. Administrators emphasized this point in commenting on the 26-year record of experience with dependable Gas Cooking Tools.

But these officials also stressed the fact that GAS has the speed and versatility to provide 2500 meals daily from the compact hospital kitchen. Furthermore, the automatic temperature controls on the roasting oven permit slow-cooking of meats with minimum shrinkage while retaining full flavor and vitamin content.

The real service capacity of modern Gas Equipment is demonstrated by the list of units in Queen of Angels Hospital—

6 heavy-duty ranges	3 coffee urns
1 broiler	1 toaster
1 deep fat fryer	1 steam cooker
6 steam tables	2 bain maries

When planning cooking, baking, and food service installations—when expanding or modernizing existing facilities—the advantages of GAS and modern Gas Cooking Tools recommend their universal use. There's a GAS unit with the proper capacity and flexibility for any type of service—ask your Gas Company Representative for details.

AMERICAN GAS ASSOCIATION
420 LEXINGTON AVENUE, NEW YORK 17, NEW YORK

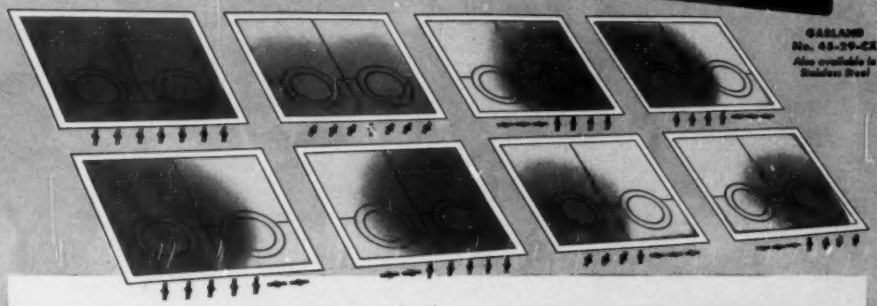
1 * 2 * 3 * 4 * 5 * 6 * 7

Front Fired Burners Give Unequaled Top Heat Flexibility! ONLY

GARLAND

the leader Has This Feature

GARLAND
No. 48-29-CX
Also available in Stainless Steel



GREATEST FEATURE ON ANY HEAVY DUTY GAS RANGE! *Seven front fired burners* that distribute controlled heat to every part of the cooking top! *Seven front fired burners* that permit an infinite number of heat variations all over the hot top.

Yes, Garland—and *only* Garland—has this great feature! Garland is the most flexible, the most practical of all Heavy Duty gas ranges!

Think of the time saved—think how *much faster*, how *much better* the chef can prepare meals when he has the right degree of heat when he wants it, *where* he wants it.

And remember: this is only one of the many big features that make Garland the leader in sales, the leader in value! So before you buy, see your Garland dealer! Compare! Your choice will be *Garland!*

MERIT AWARD

ALL Garland units are available in Stainless Steel and equipped for use with manufactured, natural or L-P gases.

GARLAND*

THE TREND IS TO GAS

FOR ALL COMMERCIAL COOKING

Heavy Duty Ranges • Restaurant Ranges • Dinette Ranges • Broilers • Deep Fat Fryers
Toasters • Roasting Ovens • Griddles • Counter Griddles

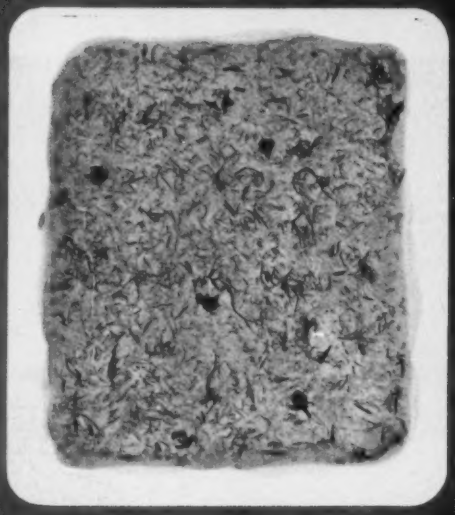
PRODUCTS OF DETROIT-MICHIGAN STOVE CO., DETROIT 31, MICHIGAN

*REG. U. S. PAT. OFF.

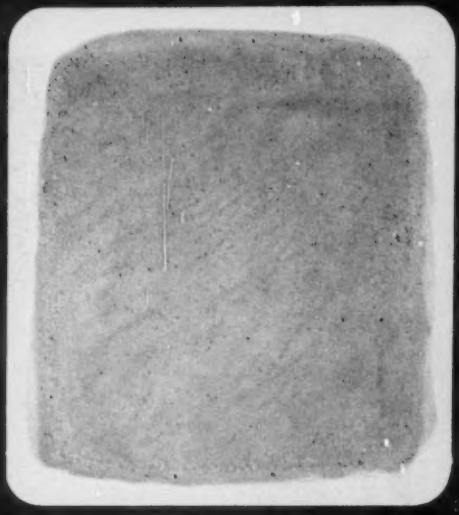
X-RAY PROBLEMS?

Put your confidence in GE X-Ray!

GENERAL ELECTRIC
X-RAY CORPORATION



ORDINARY SURFACE CHROMICIZING—Residue of undigested knots and fragments from absorption test described below.



ETHICON'S TRU-CHROMICIZING process permits complete absorption, leaving no undigested residue.

You get no undigested knot or surface residue from Ethicon's exclusive Tru-Chromicizing

UNIFORM, COMPLETE ABSORPTION GIVES TRULY ABSORBABLE SUTURES

Here is a test anyone can make to determine the degree of absorbability of chromic surgical catgut sutures.

The illustrations above are from kodachromes of glass plates containing residue from digestion experiments with surface-chromicized gut and Ethicon Tru-Chromicized Gut.

Loops of gut were tied around a glass tube and immersed in 1% trypsin solution for 200 hours, in which period the enzyme solution was renewed twice. The time of 200 hours is comparable to 6 months in tissue.

At the end of 200 hours the residue was spread on glass plates. The undigested knots and fragments from each method of chromicizing are shown in the illustrations above.

TRU-CHROMICIZING MAKES THE DIFFERENCE

How Surface Chromicizing Works

In surface-chromicized gut the chrome is found mainly, if not exclusively, in a surface layer. The surface has a high, and the core a low, chrome content. This results in a strand with a surface so resistant that it requires excessive time for digestion by tissue enzymes—contrary to what is expected from an "absorbable" suture.

How Tru-Chromicizing Works

In Ethicon's exclusive Tru-Chromicizing process, the individual ribbons of raw gut are chromicized before they are spun and dried. The chrome is evenly distributed and each portion of the strand, throughout the cross-section, has the same chrome content and enzyme resistance.

Thus the uniform distribution of chrome in Ethicon's ribbon-chromicized catgut assures the retention of tensile strength throughout the normal healing cycle, with an adequate safety margin for delayed healing. This process still permits the use of chrome contents that allow complete digestion of the gut when the need for sutures is passed.

OTHER BENEFITS YOU GET IN ETHICON SURGICAL GUT

The exclusive Tru-Gauging Process gives you greater uniformity of tensile strength from end to end of the strand.

All sizes of Ethicon Gut, while accurately gauged to U.S.P. dimensions, have breaking strength at least 30% in excess of U.S.P. minimum requirements.

ORDER FROM YOUR SURGICAL DEALER

ETHICON SUTURE LABORATORIES

INCORPORATED

Suture Laboratories at New Brunswick, New Jersey; Chicago, Illinois; Sao Paulo, Brazil; Edinburgh, Scotland; Sydney, Australia

The Surgiset

SKIN CLOSURE SUTURES

FOR YOUR OFFICE OR EMERGENCY ROOM

Complete Emergency Suture Assortment IN STERILE PACK JARS, READY TO USE

NEW...*A handy way of having your sutures always readily available.*

NEW...*Stronger needles: Fine sizes for facial wounds; heavy sizes for toughest skin.*

You don't waste time boiling tubes when you have the Surgiset. The germicide in the jars keeps tubes sterile.

Surgiset contains 3 dozen Atraloc eyeless needle sutures: 5-0 monofilament nylon on small cutting needle for facial repair; 3-0 dermal on medium cutting needle for normal skin repair; 2-0 dermal on heavy cutting needle for heavy skin.

Surgiset contains an extra jar for storing your other sutures.

Supplied complete with chrome-plated rack for the regular price of 3 dozen emergency sutures. (Jars and rack given without charge.)

When you need a fresh supply, additional jars of nylon or dermal sutures may be ordered individually by code number as shown on label.

ORDER FROM YOUR SURGICAL DEALER—CODE, EK 3

ETHICON SUTURE LABORATORIES
INCORPORATED

How do Your Patients Rate Your Food?

● Let's face it . . . too many complaining, disgruntled, unresponsive patients get that way because they don't like the food they get. And that kind of patients can make it tough for everyone . . . doctors, nurses, dietitians and the patients themselves.

But don't blame your dietitians. They're seeing that good, nourishing, tempting food is prepared. The catch is this—how does that food look and taste when it reaches the patients?

The Mealpack System guarantees that hot or cold foods will still be that way when they're served . . . and stay that way throughout the meal. It saves floor space and eliminates floor pantries. It will more than pay its own way in virtually any hospital, old or new!

The Mealpack System *has been given the acid test of comparative surveys in hospitals of every type and size. It has proved itself, without exception. On that basis, we invite you to investigate this system and its many vital advantages.*

***Write** for the detailed story of The Mealpack System*

mealpack

A SUBSIDIARY OF AMERICAN HOSPITAL SUPPLY CORPORATION

"That's when we began using White Knight Linens"

The chart above reflects the experience of many hospitals throughout the country. Better service and reduced costs go hand in hand with the use of White Knight Linens.

What could be more natural? Real costs are always determined by grade and length of service. And White Knight Linens are notable for both *good* service and *long* service.

Again, what could be more natural? For, White Knight Linens are specially selected for hospital use. Blankets, sheets, bed spreads, towels and toweling, yard goods, table linens — all must *prove* their worth before they are given the White Knight Label.

If you are not already using White Knight Linens make it a point to test some against your present supplies. Remember that White Knight Linens, like every other item in the Will Ross, Inc. line are sold with an *Unconditional Guarantee.*

White Knight Linens are sold only by Will Ross, Inc.

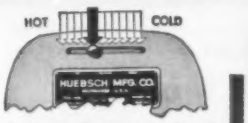
WILL ROSS, INC.

Manufacturers and Distributors of Hospital and Sanatorium Equipment and Supplies

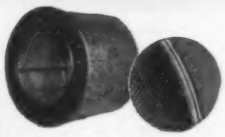
Milwaukee 12, Wisconsin

for fast laundry drying

Leading Institutions rely on . . . HUEBSCH open end TUMBLERS Cut Laundry Overhead



One-Lever Temperature Control provides complete range of temperature adjustments from hot to cold for faster, better drying.



Exclusive Huebsch "Spun-Lock" Cylinder construction insures a longer life of drying service.

Compact construction . . . Huebsch Tumblers, used individually or in a battery, cost less to run and maintain. Low initial cost.

FOUR SIZES

36″ x 18″ 36″ x 30″
36″ x 24″ 42″ x 42″

PRICES BEGIN AT

$400.00

● When your laundry is equipped with Huebsch Tumblers, your costs for drying operations hit rock bottom. You're sure of getting faster drying at lower cost. For proof of Huebsch superiority, check the leading laundries and drycleaners who have bought more than 70,000 Huebsch Open-End Tumblers . . . more than all other makes combined!

You'll be amazed at how easily the Huebsch Tumbler takes the day-after-day punishment of drying capacity loads. It's built to last . . . to give you trouble-free service. It's compactly designed to save floor space . . . and make your operator's job easier and quicker.

Every design feature has been proved practical. No fancy trimmings . . . no unnecessary panel housings to make maintenance difficult. Important parts such as the motor, reduction drive and coils are in the open so that they can be easily serviced.

When you invest in laundry drying equipment, be sure it's the best . . . HUEBSCH. See your Huebsch representative or write, wire or phone us.

MORE THAN 70,000 HUEBSCH TUMBLERS IN SERVICE

. . . Built *better* . . . designed *better* by HUEBSCH

HUEBSCH Originators

INVENTOR AND WORLD'S LARGEST MANUFACTURER OF OPEN-END DRYING TUMBLERS

Makers of the famous Huebsch Handkerchief Ironer and Fluffer Pants Shaper Automatic Valves Feather Renovator Double Sleever Collar Shaper and Ironer Garment Bagger Cabinet and Garment Dryers Washometer Hosiery Ironers Spring-Type Filter.

Small Hospital Questions

Staff Organization

Question: In connection with the development of our staff constitution and by-laws, some of the physicians were afraid they would not be able to do everything that they are doing now if the proposed section on general practice were to be approved. The staff voted on it, and the vote was in favor of including the paragraph on general practice, even though there were a few dissenting votes cast.

The committees we expect to appoint are: medical records committee, program committee, credentials committee, necropsy committee and fracture committee. Should we also have a committee on general practice?

We have 18 active staff members and several doctors on the associate staff who practice in our hospital, but who are active staff members at another hospital in this city. Do you think it would be well to invite the latter to join our active staff?—R.E.W., Ill.

ANSWER: It would seem that you are pretty well provided with committees. Somewhere among these committees, either the medical records or the credentials committee, or possibly the necropsy committee, should make it part of its function to study the pathologist's reports on tissue removed at surgical procedures to see whether the preoperative diagnosis coincides with the pathologist's diagnosis on the surgical tissue. The doctors on your staff, as well as the group operating the hospital, recognize the importance of being certain that no individual doctor has normal tissue in excess of 12 to 15 per cent on his operative cases; being certain of this is one of the important jobs that the staff and the governing board of a hospital have to do.

As Dr. Malcolm T. MacEachern has said, it is important that no doctor be allowed to do any work which is beyond the scope of his training and ability. This is, of course, the position taken by the American College of Surgeons and all authorities in the hospital field.

It would seem that if the few doctors who are on the staff of the other hospital but not on your attending staff are good, competent men, it would be wise to invite them to join your staff also.—E. W. JONES.

Introducing the Hospital

Question: We are in need of suggestions for an official opening illustrative leaflet to be used in connection with the forthcoming dedication of our new hospital wing.—Sr. M.F., Sask., Can.

ANSWER: It is difficult to make specific suggestions without knowing how intensively you wish to distribute such publicity and how much you have to spend on it. Ideally, such a leaflet would include photographs of each of the main departments in the new facility, with a brief text describing the department—of course, emphasizing in each case the improved service to the community that the new facility makes possible.

It is customary in these things for the sections describing the new building and equipment to be preceded or followed by additional text describing the hospital as a whole and again emphasizing the service that it renders to the community. Most public relations people today believe that the briefer the text the wider the readership and the more effective any such piece is likely to be.

If you do not have funds or do not contemplate an elaborate printed leaflet of this nature, a rather effective piece might be done in a somewhat simpler form following the same content but, of course, in this case necessarily omitting the illustrations. If it can be managed, however, something that includes pictures would certainly be more effective.

How Much Vacation?

Question: What is the thinking of authorities as to the extent of vacation leave that should be allowed the administrator of a 300 bed general hospital, operating all services, with an active outpatient department, an active psychiatric service and a service for acute tuberculosis?—E.G., Fla.

ANSWER: Vacations for administrators of hospitals of all sizes run anywhere from two weeks to five weeks a year. There is a tendency for boards of trustees in the larger hospitals (that is, those over 200 beds) to grant the administrator a full month's vacation with pay each year. This trend recognizes that a hospital administrator has one of the most difficult tasks in our society; the hours are longer, there is more strain from contacts with many people and from the tension and pressure that emerge from the nature of the hospital's work.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Alta, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

To Promote Indigent Program

Question: As the superintendent of a small hospital, how can I help the indigent care program in my state?—M.W., Wash.

ANSWER: In the first place, through the use of a standard hospital chart of accounts you can establish your true cost per patient per day. You can then work up a report for your board of trustees showing the number of patient days for state, city and county welfare cases, giving the cost per day and the total cost for the year of caring for these patients. Then compare this with the average income per patient per day from the welfare department for these same cases. You can then show the unit loss per day on all welfare cases, and the total dollars lost in the year.

This information should be made available to your state hospital association. It should also be made available to every member of your board of trustees, every doctor on your staff and every employe in your hospital, so they in turn can make known to their friends just what losses the hospital is incurring giving care for indigent patients. If every hospital administrator would do this a great number of citizens of every area in the state would soon realize just what the hospital is up against from a financial standpoint because of inadequate payments from welfare departments for the care of indigent cases. This in turn would be a great aid in convincing the legislators of the state and officials of the local governments that they must lay plans to pay voluntary hospitals on a reimbursable cost formula for the care of indigents. State hospital associations, city hospital councils, and individual hospitals must work together on this problem.

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Looking Forward

Let's Do It Right This Time!

AS THE war news worsened last month, gloom settled on the nation like a cold winter fog. Through the fog, it was possible to see the dark shape of a familiar, jail-like structure — the planned defense economy in which business-as-usual seemed certain to be imprisoned for years to come. As the nation's business moved glumly closer to the outer walls of the prison, it suffered more from uncertainty than from anything else. For weeks, or perhaps months, it would be impossible for any group to know the size and shape of the cell it was destined to occupy.

For many hospital people, uncertainty was already presenting problems that seemed impossible to come to grips with. In half a dozen Washington offices, letters, telegrams and long distance calls were piling up from worried administrators and trustees across the country: "Our contractor won't bid unless we can get him a priority on steel. How should we proceed to get this right away?" "Building held up pending availability copper tubing. Please advise." "Delivery needed equipment postponed. Can you help clear this up?"

In mid-December, there was still nothing Washington could do about these pleas. As yet, there were no priorities for hospitals, no way to proceed toward clearing delivery of steel, or tubing, or medical equipment. To the hospital whose building was slowed or stopped or whose operations were hampered by shortages, it mattered little whether the needed material had actually disappeared into a defense industry or was simply being withheld somewhere along the line by a supplier whose own operations were plagued by uncertainties. In the mind of every administrator who faced this kind of problem, one question was waiting to be answered: "Is it going to be as bad as it was last time?"

The way things were moving in Washington last month, it seemed unlikely that the wild hassle of 1942 and 1943 would be repeated. There were many similarities, but there were some hopeful differences. For one thing, health needs were in everybody's mind. There was an office of health resources in the National Security Resources Board. As early as November, the Federal Security Agency had been named a "claimant agency" to deal with the National Production Authority on civilian health needs—specifically, for "estimating, presenting and justifying" such needs. If the machinery for presenting and justifying claims for hospital priority was not yet in readiness, the estimating machine was already beginning to spin inside the F.S.A.'s Public Health Service. But the most hopeful sign of all was the fact that in the Public Health Service there were able men and women who knew the civilian hospital economy and understood its predicament. It seemed certain that they would be called on to help chart the course hospitals would have to take through the defense fog. Last month, they were ready to be called.

However able the navigators, the course was sure to be twisted, narrow and rocky, with many a treacherous shoal that would be difficult to avoid. Thus it seemed sensible to ask for advice from a man who knew these tricky waters as well as anyone could. As hospital consultant to the War Production Board during World War II, Everett W. Jones had come aboard in mid-channel last time and had to steer his way without the aid of charts. Last month, he looked out across the water and saw some familiar, threatening rip-tides and a few buoys warning of dangers already recognized.

"The lack of action in the early months of 1942 was undoubtedly caused by the failure of W.P.B.'s top officials to recognize the vital rôle of hospitals in maintaining a high level of health and hence supporting an all-out war effort," Mr. Jones recalled. "In the early days of W.P.B., hospitals had to file priority applications with many different bureaus, divisions, branches and sections. These applications were then handled by dozens of well meaning people, most of whom had only the foggiest idea of the importance of civilian hospitals in the war effort and the need for the supplies and equipment that hospitals had to have to continue their work.

"Applications for such mechanical and electrical items as boilers, stokers, pumps, motors and switchboards were being processed, or buried, by people who had no conception of the use of steam and electricity in a hospital. Applications for professional and technical equipment were being handled by former leather goods and insurance salesmen. These men meant well, but they just didn't have the background of training and experience needed for their difficult W.P.B. jobs.

"Hospital construction applications were shunted around from one bureau to another. Applications for city, county and state hospitals went to one office and those for nongovernment hospitals to another. If it hadn't been for the early work of such men as Dr. James Crabtree and Dr. Vane Hoge of the Public Health Service, the situation would have been far worse than it was.

"W.P.B. and the Federal Works Agency had issued regulations specifying what kinds of hospitals could be built and what type of construction and materials could be used," Mr. Jones continued. "These regulations were issued without advice from practical hospital executives, architects and consultants. An example of the orders which emerged was one limiting hospitals, regardless of size, to the impractical, wasteful, one-story, pavilion type of building. This type was specified with the mistaken idea that critical materials would be saved. Apparently

no thought was given to the fact that civilian hospitals were crippled with a critical shortage of employes, and that no one but the army could possibly get enough help to run this single-story type of hospital when the size exceeded 75 or 100 beds.

"One man in Washington—Maury Maverick, chief of the government requirements bureau in W.P.B.—really seemed to appreciate the importance of hospitals as the foundation of civilian health. Furthermore, he realized the need for one central agency, manned by experienced hospital executives, to handle applications for everything needed in planning, building, equipping and operating hospitals. With his help, the suggestion that a committee of hospital representatives had made to the W.P.B. was finally adopted, and the hospital section was organized. For the next six months, there was a struggle to get the new section staffed with experienced hospital people and accepted by all groups in W.P.B. and other federal agencies, and by hospitals themselves. These experiences from World War II should point the way to avoiding the same mistakes again."

Specifically, Mr. Jones urged federal agencies responsible for war-time planning to make certain the following steps had been taken or were taken immediately:

1. Recognize the fundamental importance of hospitals in keeping the population healthy and hence able most effectively to carry on an all-out war effort.

2. Estimate total quantities of all building materials, mechanical, electrical and food preparation and serving equipment and professional equipment needed for hospitals and other health agencies called for in the master plans for health facilities developed in each state. Also estimate operating supplies needed as original stock to put these facilities into operation.

3. Obtain annual consumption figures for all kinds of operating supplies from a large enough sample of hospitals to permit reasonably accurate estimates of total annual consumption needs of all hospitals. Also estimate annual equipment replacement needs.

4. Make certain civilian hospitals get the best materials for building and equipment. ("The average community group can't afford to operate a hospital in which shoddy materials have been used, inevitably with higher maintenance costs soon after operations begin," Mr. Jones explained. "If galvanized iron sterilizers and work tables and other such substitutes must be used, let them go into the temporary armed forces hospitals, and give the permanent materials to civilian hospitals. The long-term soundness of this should be self-evident. It does not mean at all that we shouldn't be giving the very best care to members of the armed services. It's simply a question of manpower. The armed services can get all the help they need to operate their hospitals; civilian hospitals cannot command even the minimum essential personnel.")

5. Establish a priority and allocations system which will guarantee that hospitals and health agencies have their proper place of importance in the whole economy. ("We dare not rate hospitals and beauty parlors in the same category, as was done far too long last time!")

6. Assign the job of looking after the needs of all civilian hospitals to the Public Health Service, whose appropriate divisions are staffed with able executives experienced in hospital administration, planning and engineering and in laboratory, pharmacy, nursing, dietary and other related operations. With the additional offices and staffs needed to operate an allocations system, these people can see the job through.

7. Appoint an advisory council of persons experienced in all phases of hospital and health planning and administration, to advise and consult with public health and production authorities in Washington and in the field. ("In addition to appropriate representation from hospital, medical, nursing and related organizations, this group should include representatives of the Hospital Industries Association, American Surgical Trade Association, Surgical Manufacturers Trade Association, American Pharmaceutical Association and others familiar with the suppliers' problems.")

For hospitals themselves, Mr. Jones had these recommendations:

1. Intensify efforts to train personnel in labor-saving methods and conservation of equipment and supplies. Speed up action looking toward standardization of supplies and simplification of procedures in all hospital departments.

2. Establish recommended stock and inventory control records and methods. ("As items needed by civilians become scarce, losses from hospital stocks will increase. Such losses must be stopped. Hospitals must be ready to furnish consumption data to federal agencies on short notice.")

3. Stop scare buying! Don't build inventories up beyond normal operating needs plus authorized civil defense requirements. ("Under the Defense Production Act, the National Production Authority is empowered to requisition 'excess' inventories.") Order equipment for new buildings as far in advance as possible.

4. Stop placing orders for the same items with several manufacturers or suppliers and canceling duplicate orders when one shipment is received. ("This makes intelligent planning impossible and needlessly complicates the whole manufacturing and distributing problem. Work with your suppliers, and they will help you!")

5. Make up your mind that "business-as-usual" is at an end. ("When they really understood the seriousness of the situation during the last war, hospital administrators cooperated splendidly with W.P.B.")

6. Prepare now for the elimination of all luxury services and organize for the best possible care of patients under war-time conditions. ("Plan now—don't wait! Start building volunteer organizations that will help staff all hospital departments if personnel shortages should become severe.")

7. Don't wait for civil defense and production authorities to tell you what to do. Get together now with your local and state associations to develop estimates and statements of your problems and needs. ("Regional planning and coordination of services will be essential to effective war-time operation of hospitals.")

"By acting wisely now, we can avoid many of the mistakes that caused costly delays and misunderstandings during the early days of World War II," Mr. Jones concluded. "Fortunately, hospitals and their organizations are stronger today than they have ever been before, and we have learned how to work effectively with government agencies and officials. The experience of hospitals during the war and postwar years should help us avoid the same mistakes during the present emergency, however severe it may become."

Above: St. Vincent's Hospital, Bridgeport, Conn. Green Kalistron wainscoting. Architect—Fletcher Thompson, Inc.

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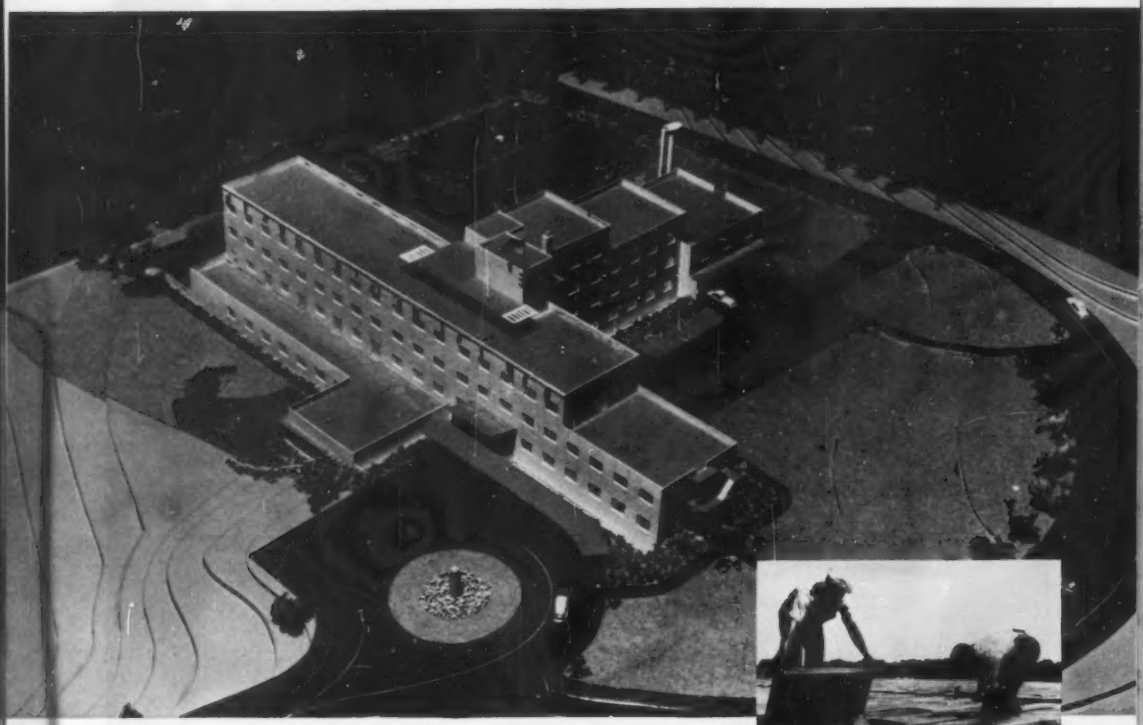

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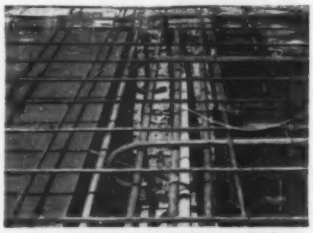

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The Old Alexander Plunges Ahead

For twenty years Dr. Wilinsky has been preaching integrated health service, and now the idea is beginning to take hold

WHEN plans for a $6,000,000 addition to Boston's Beth Israel Hospital were under discussion some years ago, one of the early planning sessions was treated to a major oration by a member of the hospital's medical staff, who sought to demonstrate that his department couldn't possibly carry on effectively without greatly expanded space. After the doctor finished his impassioned plea for professional *lebensraum,* somebody asked Dr. Charles F. Wilinsky, Beth Israel administrator, what he thought. In a spontaneous, two-minute reply, Dr. Wilinsky tore the staff man's report to shreds, reeling off reams of statistics which proved conclusively that the department already had more space than the accepted standard for its volume of work. "It was a dazzling performance," a hospital architect who was present at the meeting recalled not long ago. "We never heard another word about the needs of that department, either," he added.

Facts and figures that most hospital people would have to spend hours developing are always on the tip of Wilinsky's tongue, according to the architect, who has worked with hospital administrators throughout his professional life. This circumstance is all the more remarkable when one considers that hospital administration is Wilinsky's second, and adopted, career, rather than his life work. When he became president of the American Hospital Association last September, he was touching top goal for the second time: He had been president of the American Public Health Association the year before. In addition to being director of Beth Israel Hospital, Wilinsky has also been for many years deputy commissioner of health for the city of Boston—a combination of functions not unlike that of Dmitri Mitropoulos, the musician, who is a piano virtuoso as well as a symphony director and has frequently appeared in the dual rôle of conductor and soloist on programs featuring the piano concerti. During these extraordinary performances, Mitropoulos appears to concentrate most of his attention on the piano, occasionally giving the orchestra the beat with vigorous nods of his bald head or bringing up the woodwinds, say, with a wave of the arm. In much the same way, Wilinsky has seemed to focus interest and attention for the last twenty years on the hospital, which has grown from 175 to 400 beds during his administration and is still in the midst of its huge expansion program. Yet his ear has been sharply attuned all along to the operation of Boston's chain of public health centers, which has been his chief responsibility in the health department since he established the famous Blossom Street Clinic in 1916. Like Mitropoulos, Wilinsky never neglects either of his jobs in favor of the other. Rather, he sees them as only slightly differing phases of a single function; in his view, the hospital and public health are as closely related and interdependent as the piano and orchestra parts of a concerto.

In recent years, it has become fashionable for medical economists and theorists to sing the advantages of the fully integrated health facility, with hospital, public health department and doctors' offices either established under

R. M. CUNNINGHAM Jr.

the same roof or located in adjacent quarters. Under this arrangement, it is pointed out, those who share the responsibility for community health can avoid wasteful duplications of staff and equipment and can more easily exchange information and ideas looking toward the better performance of their several duties. Instead of dividing the citizen's health, like all Gaul, into three parts, this theory sees total health as the constant goal of a community's preventive, clinical and social services. While special emphasis on one or another of the services may be called for at any time or for any person or family, their existence as independent, unrelated entities is as out of date as the old-fashioned mustard plaster.

REGARDED AS UNORTHODOX

If the integrated health service has become a familiar theme today, however, it was regarded as radical dissonance when Wilinsky wrote the music twenty-odd years ago. While his ideas have gained widespread acceptance among hospital and public health people, most private physicians have refrained from throwing hats in air at the suggestion that they should join hands with hospitals and health officers; in orthodox medical circles, such views are looked upon as a violation of good taste, like wearing brown shoes with a blue suit. When Wilinsky suggested, during a debate at a meeting in Indianapolis some years ago, that public health officers should concern themselves with the organization of medical services for the diagnosis and treatment of disease, as well as with problems of sanitation, water supply and immunization, doctors in the audience couldn't have been more shocked if he had proposed turning the practice of medicine over to the Campfire Girls. This was definitely the attitude of his opponent in the debate, a doctor who regarded public health men, medical school deans and other salaried physicians as of lesser stature than the true, or fee-for-service, species and insisted that clinical practice should be marked off from all other forms of medical responsibility, like the free-throw circle on a basketball court. Public health doctors should stay outside the circle and mind their test tubes, he implied, leaving the care of the sick to those who know the score.

Since the debate at Indianapolis, a sizable fraction of the medical world has been persuaded to share Wilinsky's conviction that this compartmentalized concept of health care only makes it harder for everybody to get the job done. While there are still many doctors who rank the billhead alongside the diploma as a badge of clinical competence, the public health officer is no longer invariably regarded as something *outré*, like an acrobat in a family of bankers.

If Wilinsky's views on public health are less heterodox today than they were twenty years ago, his political and social philosophy is still somewhat to the left of Fishbein's point, or the midline of American Medical Association policy. Moderate enough by any other orientation, Wilinsky believes that the federal government has a proper and important function in health care. He vigorously opposes compulsory health insurance, but he sees federal grants-in-aid for indigent care, insurance plans, hospitals, professional education, and special programs in cancer, tuberculosis, venereal disease, mental hygiene and care of crippled children as necessary and desirable steps toward better health for the whole population, and not as sinister moves in a fiendishly devised socialist plot to seize control of the country. It might be argued that Wilinsky and others who favor government aid are simply being practical about getting needed things done, and it is those who moan about "creeping socialism" and try to stop the clock who have invited the public criticism of medicine that is threatening the system, but the chances are that Wilinsky himself would not argue the point either way. Arguments pain him.

Whatever doctrinaire medical economists think of Wilinsky's views, however, they can scarcely dismiss him out of hand as a theorist. Few men have had broader experience in all phases of medical care, including private practice, which Wilinsky gave up reluctantly a few years after he took over the administration of Boston's public health clinics. Unquestionably, one of the reasons for his reluctance to forswear practice was family tradition; Wilinsky's father was a general practitioner in Lowell, Mass., for many years after emigrating to the United States from Warsaw, Poland, in 1892. Wilinsky, who was 10 years old at the time the family arrived here, went to public schools in Lowell and then to medical school at Baltimore University, at a period when undergraduate college training was considered an unnecessary diversion and high school students bent on medical careers often went directly from commencement to cadaver. Wilinsky began practicing at 22, an age when today's students are just starting to learn the names of the long muscles.

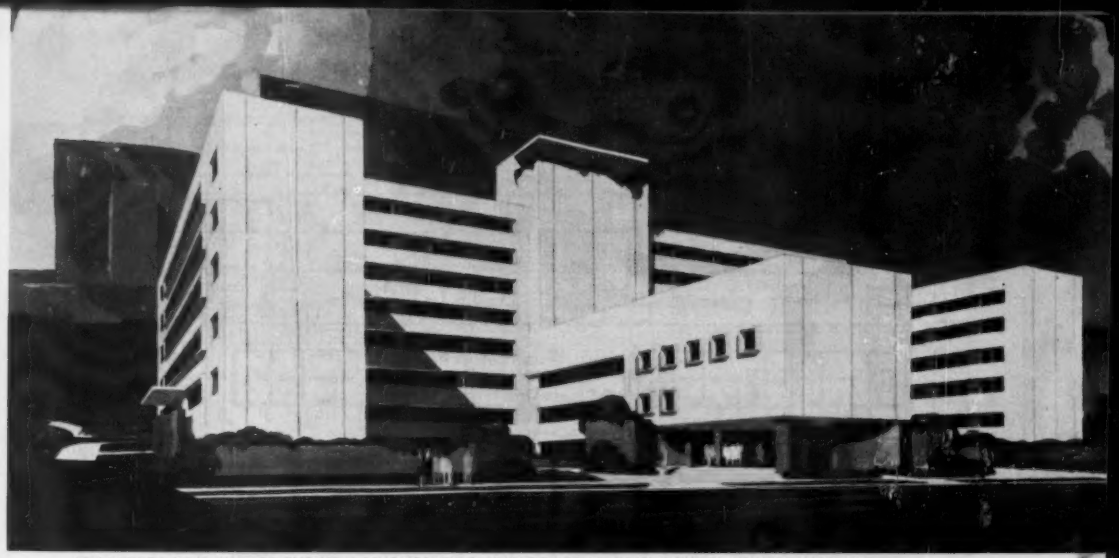
Wilinsky might still be carrying a black bag around Boston, his talent for administration undiscovered, if he hadn't attended a meeting at the home of Dr. Richard Cabot one evening in 1914. As a young medical graduate, Wilinsky was practicing in Boston and had taken a part-time job as a school physician. This work brought him in contact with Boston's poor families, and changed the entire course of his career. Faced with all the problems created by an illness in the family, Wilinsky found, the workingman might have to go to as many as ten different places to get help. Charity abounded, but it was so diffused and disorganized as to be almost useless in many instances. The wastefulness and absurdity of this situation appalled Wilinsky and a few others and they got together at the Cabot home to talk things over and see what could be done.

SO HE TOOK THE JOB

At about that time, the late Dr. S. S. Goldwater, as health commissioner of New York City, was establishing neighborhood clinics throughout the city, and a similar program was under way in Buffalo N.Y. Picking up the health center idea, Wilinsky's group decided the sensible thing to do was to put all the services needed by poor families under one roof. The city had a welfare station on Blossom Street, in the shadow of Boston's famed Massachusetts General Hospital, and Wilinsky talked to Mayor James Curley about turning it into a complete health center, bringing all the preventive, clinical, nursing and welfare services offered by the city's public and private charitable agencies under a single administration. Curley, a man who has had his ins and outs but has always been a friend of the poor, agreed—provided Wilinsky would take the job. He did.

The logic of the Blossom Street idea was immediately apparent, and the center was a success from the day it opened. A few years later, when a Boston philanthropist named George R. White died and left the city $6,000,000 to be spent for "useful pur-

(*Continued on Page* 122.)



ARCHITECT'S DRAWING OF THE NEW PSYCHOPATHIC UNIT OF LOS ANGELES COUNTY GENERAL HOSPITAL

PSYCHOPATHIC UNIT *for short-term care*

provides institutional care in un-institutional surroundings

ADRIAN WILSON
and
PAUL R. WILLIAMS
Architects, Los Angeles

THE plan for the new psychopathic unit of Los Angeles County General Hospital was developed to provide diagnostic service and short-term care (20 days' maximum) for all classes of mental patients. This unit, which replaces another building on the hospital grounds, will house 265 patients and have a floor area of 126,000 square feet.

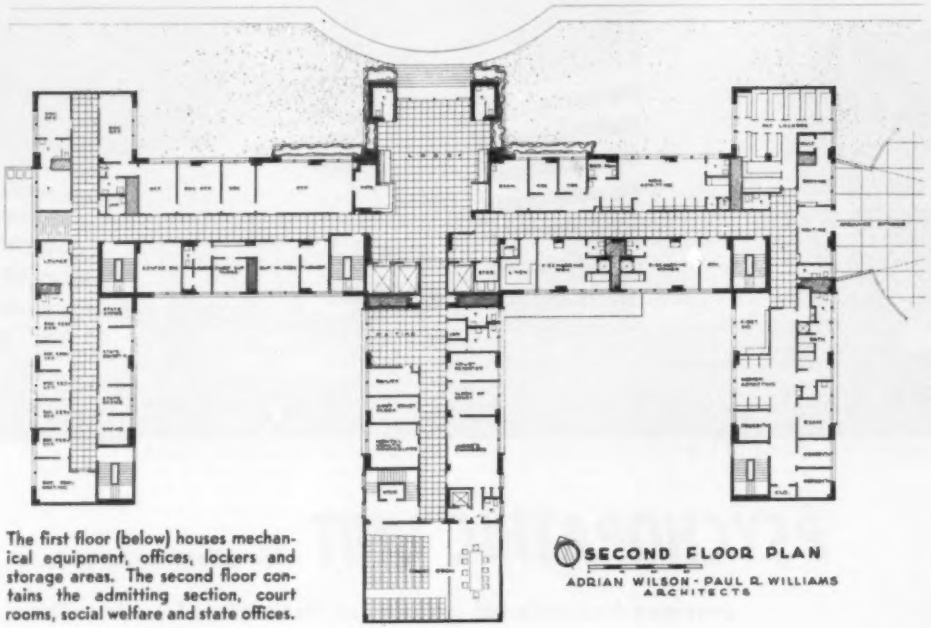
The major departments provided are: administrative, clerical, social service, state offices, department of mental hygiene, superior court, and the various patient areas.

California state law requires that a patient may be confined for not more than 20 days, and that if he is sent from this unit to a state or private institution or to his home he shall be sent by superior court commitment; hence the courtroom with its facilities. Among the duties of the staff of doctors is the determination of the patient's mental condition; the social service department and the department of mental hygiene, through investigations and interviews, determine the patient's social background, financial standing, home conditions, and so forth. Office space, with areas for interviewing and investigation work, are provided. This information is compiled, and it is from this information the judge determines the place of commitment. Court may be held either in the courtroom or, if necessary, at the patient's bedside.

During the fiscal year ending June 30, 1948, 3875 male and 3325 female patients were admitted to the existing psychopathic unit. Their average length of stay was 5.4 days. Of this number, 1110 were returned from probation from state institutions.

The new psychopathic building is being built on the grounds of the existing general hospital. While it is a separate building, it is to be a unit of the general hospital and will use various facilities already provided. There now exists a power house from

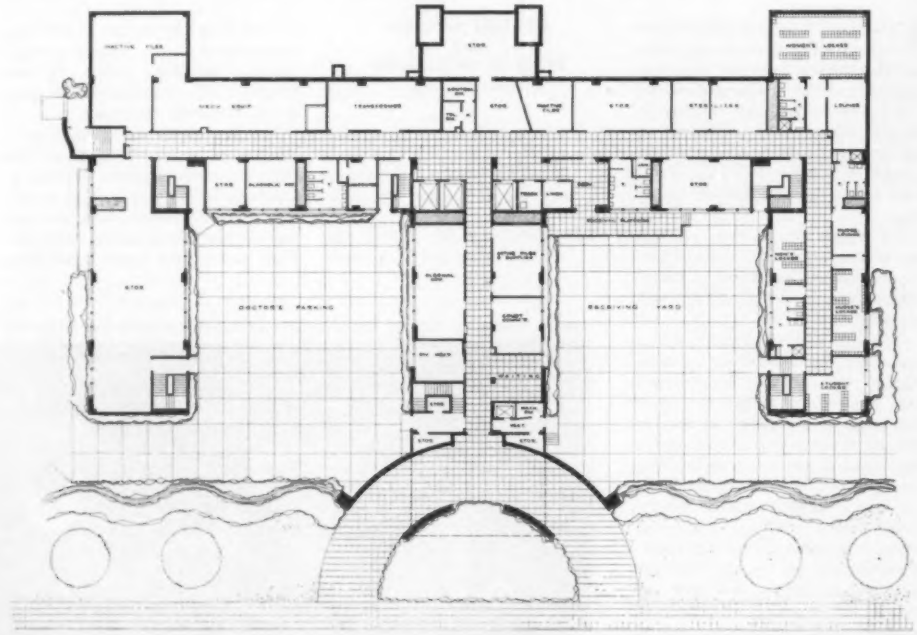
ARROW POINTS TO SETTING OF PSYCHOPATHIC UNIT ON HOSPITAL GROUNDS



The first floor (below) houses mechanical equipment, offices, lockers and storage areas. The second floor contains the admitting section, court rooms, social welfare and state offices.

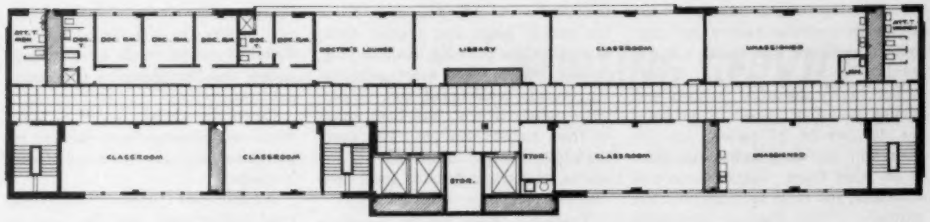
SECOND FLOOR PLAN

ADRIAN WILSON - PAUL R. WILLIAMS
ARCHITECTS



FIRST FLOOR PLAN

ADRIAN WILSON - PAUL R. WILLIAMS
ARCHITECTS



The eighth floor (above) has classrooms, study rooms and library. This is perhaps the only mental hygiene building with educational facilities on the premises for students and interns. Below: One wing of the third floor is used for offices and the rest is devoted to wards and day rooms.

THIRD FLOOR PLAN

ADRIAN WILSON - PAUL R. WILLIAMS
ARCHITECTS

which this new unit will receive its steam for heating and sterilizing, and a large modern laundry is on the grounds, which will care for all laundry requirements. A pharmacy building, which meets the needs of the other general hospital units, will serve this one as well. Provision is made on the grounds for the incineration of wastes. In the near-by acute unit is located the main kitchen, where all food preparation and dishwashing are done for all units. Prepared food will be brought to the ward kitchens in heated carts, where trays will be made up for serving patients. Staff and attendant dining rooms are located in the acute unit. Surgical suites, laboratory, outpatient, x-ray, morgue, main storage and supply are located in the acute unit and will also serve the needs of the psychopathic unit.

The major ward areas are: receiving, discharging, treatment, disturbed patients, and quiet and depressed patient areas.

Receiving. Patients will be received from the acute unit outpatient department, from private doctors, from other hospitals, or from private homes.

The receiving department is divided into sections for men and women. In each section are examining and observation rooms, dressing areas, bathing and toilet facilities. Adjacent to these areas are the admitting office, with a vault for patients' valuables and a locker area where patients' clothes are marked and stored. Upon admittance, the patient is bathed and physically examined. There are observation rooms in which patients can be housed temporarily while awaiting results of any tests that have been made. It is at this receiving area that patients are assigned to the ward they will occupy on the floors above. Provision has been made so that patients can be transferred to their assigned wards without passing through a public area.

Ward Areas. The ward areas are designed to care for all types of mental patients of either sex, one-half of each ward floor being for men, the other for women. In each ward area space is provided for a doctor's office, a consultation room, a small laboratory, treatment room, kitchen, nurses' station, utility room, linen rooms, day room, bathing and toilet facilities. Ele-

vators, storage rooms, trash and linen chutes are centrally located for common use of both men's and women's wards.

The highly disturbed patients will occupy one floor. Space is provided for the care of 52 patients on this floor, with the same facilities provided as on other floors. Single rooms predominate, and toilet facilities are more extensive. This floor is completely air conditioned, and partitions are sound insulated. Observation rooms are so located that potentially suicidal patients can be placed under constant supervision of the nurse in the nurses' station.

The quiet and depressed patients occupying two floors will be separated from the highly disturbed patients. The living quarters for these cooperative and well behaved patients will be made as pleasant as possible. A large day room is provided in each ward, and these patients will also have access to outside exercise areas and occupational therapy rooms.

Treatment and Diagnostic Facilities. This unit, together with facilities of the acute unit, will provide all treatment necessary for intensive short-term care. Since the patient's stay in this unit is of short duration, treatment must necessarily be limited to quieting the patient and alleviating his anxiety. The treatment and diagnostic facilities are as follows:

1. Continuous baths. The main tub rooms are located in the hydrotherapy and physical therapy rooms on the seventh floor; however, each ward is provided with a continuous bath tub.

2. Wet packs will be given on the beds or on movable tables in the tub rooms.

3. Salt rubs and stimulating massage will be given in the hydrotherapy rooms or in the treatment rooms in each ward.

4. Arm and leg baths will be given in movable equipment which can be used in the patient's room.

5. Sitz bath facilities are in the hydrotherapy rooms.

6. The electroencephalograph is located in a room entirely shielded with grounded copper mesh.

7. X-ray equipment is of a type that does not require lead shielding. A room has been provided for this equipment.

8. A room is provided on the seventh floor for the electrocardiograph.

9. Occupational and recreational therapy. Inasmuch as patients are confined for a limited time, this area is not unduly large, but a quiet space is provided for painting, wood carving, sewing, weaving and other activities. An outside recreational area is provided where patients can have access to fresh air and sunlight. This space is large enough for shuffle board, quoits, table tennis or other small exercise equipment.

Teaching. Four lecture rooms, a students' study and locker room, as well as a medical library, are provided for staff, student and attendant instruction. Each lecture room is connected to the speaker system, and lectures can be given by recording or other means at the broadcast room.

Discharge Area. Here, too, separate areas are provided for men and women. It is located near the receiving entrance and has facilities for bathing and dressing. It is here that the patient committed to other institutions will have his clothing returned and will wait for conveyance.

Parking and Traffic Control. It was recognized that facilities must be provided for automobile parking and that traffic must be routed to eliminate hazard. Private parking space for the staff has been provided near an entrance to the administrative area of the building. Parking space for 130 cars has been provided for public use. The receiving and discharge entrance has been located so that ambulances or police cars entering or leaving will create a minimum of hazard on near-by streets.

MATERIALS AND CONSTRUCTION

It was necessary to consider: (1) that this plan must be developed to serve the needs of a rapidly expanding community; (2) that it must be designed so that the physical structure could be changed as new types of psychiatric treatment develop; (3) that it should be of sturdy, fireproof construction, with maximum detention features, and yet be a pleasant place in which to live and work.

The building is designed structurally and mechanically so that two more floors can be added to each end wing and to the center wing, thus adding more than 25,000 square feet of floor space.

A type of construction has been used which will allow moving or removing most interior partitions. Areas can thus be made larger or smaller as future needs may require.

The building is entirely fireproof. Many areas are acoustically treated and, as a further aid to noise control, the disturbed patient wards are air conditioned and the partitions are sound deadened.

Detention screens are to be used, which will eliminate both the need for barred sash and also the hazard of glass breakage.

All doors and frames are sound deadened hollow steel, and the doors to patients' rooms have a sliding view panel of shatterproof glass.

Especially hard plaster is used, with a smooth troweled surface which will clean easily and suffer a minimum amount of damage.

All hardware will be of a sturdy special construction and care will be taken to avoid sharp corners.

Plumbing fixtures in patient areas are prison type, with push-button control. Lighting is fluorescent, with fixtures flush to ceiling. Fixtures in patient areas will be provided with shatterproof glass and will be entirely vandal-proof.

All wet areas, *i.e.* kitchens, baths, therapy rooms, utility rooms, janitors' closets, are provided with tile floors and wainscots. Other flooring is to be linoleum or terrazzo. A coved terrazzo base is provided throughout. A stainless metal bumper rail will be provided along walls of rooms and corridors where damage could occur from movable equipment.

Color will play an important part in the interior decorating scheme. Ward areas are to receive careful study, so that a home-like, cheerful appearance will be obtained. Windows will have venetian blinds, shades or draperies wherever possible. The hospital is located to take maximum advantage of sunlight, and generous quantities of glass are to be used to lighten the interior.

INSTANT COMMUNICATION

Emergency guard call, sound, broadcasting, fire alarm, telephone and communication systems of the latest type will be installed. Instant communication will be provided between various departments and other units on the hospital grounds.

A system of broadcasting will be provided, with outlets in all day rooms and recreational areas so programs can be broadcast to patients.

Construction of this unit is nearing completion. It is estimated the building plus the built-in equipment will cost $3,400,000.

effective organization of the NURSING SERVICE

leads to improved patient care

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ONE of the hospital's major services is nursing. Effective organization of the nursing department—to be studied here—can lead to consistently improved patient care. Through capable administration harassing details which interfere with constructive nursing can be eliminated and a situation will emerge where nursing personnel can function with maximum competence.

The nursing department requires both skilled and semiskilled personnel. Broadly, skills and attitudes that are the outcome of organized instruction in nursing are needed for translation of the doctor's medical plan for the patient into nursing care. A number of other services to the patient can be performed by individuals who have had on-the-job training only.

TWO TYPES OF NURSING CARE

The nursing department provides direct and indirect nursing care.

Direct nursing care is that which contributes directly to the patient's return to health and the maintenance of that state of health. It is given by the professional and nonprofessional nursing personnel under the direction of professional nurses at the bedside of patients, in the operating room, the birth suite, the outpatient department, and other patient areas.

Direct nursing care includes technical services which require the judgment and skills of the professional nurse, and personal services of an essentially hygienic nature, such as maintenance of a clean and orderly environment, food service, personal hygiene. Personal services may be given by nonprofessional personnel[1] except for the patient who because of emotional reactions or therapeutic reason requires the skills, understanding and attitudes of the professional nurse.

Indirect nursing care refers to functions that support direct patient care. It includes the management of the nursing unit; clinical and special division, and the over-all administration of the nursing service department.

Another group of indirect services may be bracketed under clerical and housekeeping services. Keeping records, compiling data, making requisitions, and caring for communications come under this heading also. So do maintenance of a proper environment and accessibility of material, supplies and equipment.

Hospital administrators, nursing service and nursing education personnel are becoming increasingly aware of the need to differentiate between the responsibilities of nursing service and those of nursing education.[2] This can best be done by adopting clearly defined titles which identify and are in keeping with service or educational responsibilities. The instructional personnel of a hospital school of nursing may have dual functions. This should be acknowledged by dual titles. For example, an assistant director of nursing may also be a clinical instructor; she should then be appointed to the position of "assistant director and clinical instructor."

To prevent misunderstanding between the employer and appointee to a position on the nursing service staff the title of the job should identify the major responsibilities of the person occupying the position. The following job definitions do not attempt to become job descriptions. Job descriptions can only be developed after a complete job analysis. They do, however, give a starting point from which a functional chart of organization could be developed. A first job of the director of nursing and the nursing staff would be the development of a functional organization chart of the nursing service department.

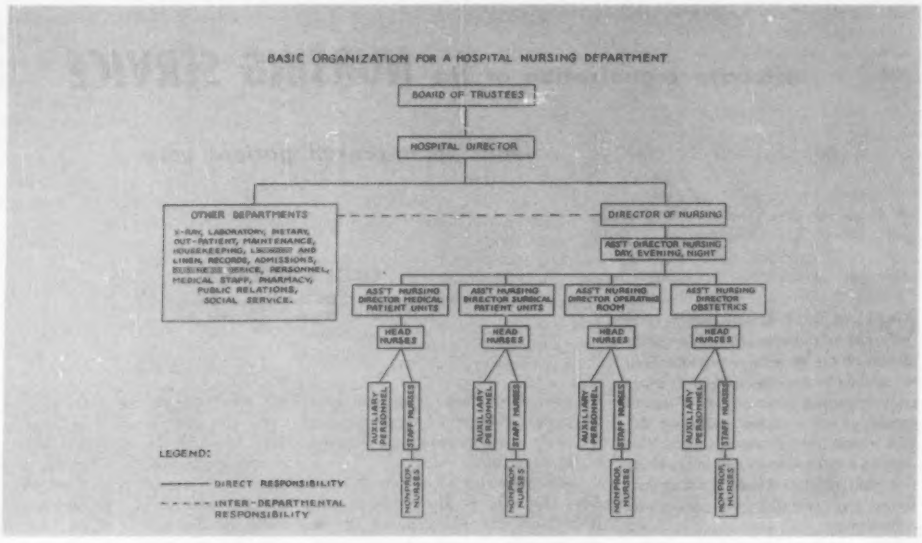
PROFESSIONAL NURSING PERSONNEL

The director of nursing service is delegated the responsibility — within the limits of the resources provided (financial, physical and so on) and the policies for patient care established by board of trustees—for the nursing care to patients. She is directly responsible to the hospital administrator and through him to the board of trustees for the conduct of the nursing department and the coordination of all nursing activities and for the integration of these activities with other departments. She plans and generally administers the nursing service, delegates responsibility, gives general supervision and collaborates with the nursing staff in determining policies and procedures for nursing care. She acts as a special adviser to the administrator of the hospital on nursing service and interdepartmental policies that affect nursing. She represents the nursing department in interdepartmental organization and policy-determining activities that affect nursing.

The assistant director of nursing service shares the responsibility of the director for the administration and coordination of functions within the nursing department. It is necessary that direction be provided 24 hours a day, seven days a week. In many instances

[1]The term nonprofessional is used in a generic sense to identify that group of nursing personnel that performs functions under the supervision of a professional nurse that would be performed by professional nurses if nonprofessional nurses were not used.

[2]Faculty Positions in Schools of Nursing and How to Prepare for Them. N.L.N.E., New York. 1946.



the night assistant director of nursing also represents the hospital administrator for certain functions which may be specifically delegated to her.

In current practice, as the size of the hospital has increased with concomitant increase in nursing staff and a sharper delineation of functions, the assistant staff has been increased. When two or more assistants are employed, they frequently have been delegated major responsibility and authority for specific areas of administration, *i.e.* equipment and supply, staffing, records and reports or other areas of administration.

SHOULD BE ASSISTANT DIRECTORS

It is suggested that nurse supervisors who are given general responsibility for administration and supervision of a major nursing division and who report to the director of nursing be designated as assistant directors. In their present capacity, supervisors may be responsible for a clinical nursing department consisting of two or more patient units, each of which is under the administration of a head nurse. Usually they have authority for determining staffing requirements and utilization, equipment and supply, inventories and staff education, in accord with established hospital policy. This administrative responsibility of the supervisor has not always been identified and recognized by title, or specifically delegated responsibility, leading to possible confusion. Designation by title as assistant director of nursing in charge of medicine, surgery, operating room or other major nursing division would bring a clearer understanding of function and authority. Such an organizational pattern would tend to decrease the number of individuals between the director of nursing and the patient.

If supervisors employed in this capacity also become advisers to the nursing administration on policy determination, each supervisor will coordinate the nursing care of patients in a particular area of specialization, such as pediatrics, public health or orthopedics, wherever needed in the hospital.

In the pattern the head nurse is delegated greater responsibility for patient care, personnel supervision and on-the-job growth and development of the staff under her direction.

She has direct responsibility for the administration and supervision of nursing personnel in a bedside unit, a clinic in the outpatient department, or a specialty service in the operating room.

A staff nurse under the supervision of a head nurse gives direct care to patients at the bedside, in the operating room, birth suite or outpatient department and may be responsible for nursing care given by nonprofessional personnel to patients assigned to her.

PRIVATE DUTY NURSES

Some patients need or desire the services of a private practice nurse She is an independent contractor, employed and paid by the patient or his family, or from philanthropic funds. She replaces members of the nursing staff at the bedside.

The hospital, however, still has a responsibility for the care patients receive. The administration must not be guilty of negligence in allowing unqualified persons to engage in the private practice of nursing within the hospital. The private practice nurse will need to cooperate with the hospital nursing staff. She must observe official channels of administrative organization and carry out administrative policies for the nursing care of her patient: the procurement of equipment, supplies, medications, diets and the like; reporting the condition of the patient, and arranging for nursing care to the patient during her absence.

These nurses are not employes of the hospital and are not shown on the organization chart. Their relationship to the nursing department should be determined by a hospital administrative committee representing the private practice nurses, hospital administration, nursing administration and the medical staff.

NONPROFESSIONAL STAFF

Confusion results when any attempt is made to compare functions of nonprofessional personnel in the nursing department of one hospital with that of another hospital because of wide variance in pay-roll classification. Titles used for job classification may mean entirely different functions in different institutions or official publications. The Council on Medical Education and Hospitals of the American Medical Association classifies all nonprofessional nursing personnel as "auxiliary nursing personnel."[3] It includes in this group practical nurses and attendants, volunteer nurse's aides, orderlies and ward maids. The Joint Committee on Auxiliary Nursing Service[4] of the six national nursing organizations differentiates between "practical nurses" and "auxiliary workers."

Recognition of the place of trained practical nurses on the health team in hospital nursing practice is gaining wide acceptance. It seems desirable that emerging trends be recognized and personnel identified in uniform terms. No comparative studies of cost, personnel needed, or service provided can be done until uniform terminology is adopted. Functional and economic waste results from blind acceptance of traditionalism. For these reasons it is urged that the following nomenclature be used to identify nonprofessional nursing service personnel:

A practical nurse is one who is prepared to care for subacute, convalescent and chronic patients and to assist the registered nurse in the care of other patients.[5] The practical nurse works as a member of the health team in promoting return to health and the preservation of a state of health.[6, 7] The team assignment gives the nonprofessional nurse more continuity and more direct professional supervision and guidance.

The use of the term "practical nurse" should be limited to those persons who have completed an approved course of preparation or the legally specified equivalent. In those states where licensure is available for this group the term practical nurse should be reserved for the licensed practical nurse.

Auxiliary workers are persons who carry out duties necessary for the support of nursing service. These may include minor and sometimes personal services for patients which do not constitute the practice of nursing and sometimes are not under the direction of nurses, for example, diet maids. Instruction to this group of workers consists of orientation and on-the-job training. They are frequently classified under four main headings:

1. Those who work within the patient unit and in clinics, operating rooms and supply rooms, often called nursing aides, orderlies, specialized technicians, diet maids and bus boys.
2. Those concerned with transportation of equipment and communication within the institution (porters and messengers).
3. Those whose duties are of a clerical nature and are carried on in or near the patient unit (clerks, secretaries).
4. Those whose duties relate to housekeeping within the patient unit. In those hospitals whose size warrants administrative departmentalization, these workers will be under the administrative control of the executive housekeeper.[8]

Training programs prepare auxiliary personnel for a specific job in a given hospital. If a worker is transferred to another position or to another hospital, he will need new training for that position.

BASIC ORGANIZATION

It has been pointed out that departmental organization of the hospital is based on the services the hospital is prepared to render. Such organization is an essential tool for control and planning. It involves placement of authority, adequate supervision of the worker in the job, and adequate budgeting for services to be rendered.

Planning for departmental activities is accomplished by:

1. Providing a means for adoption, transmission, interpretation and execution of administrative policies.
2. Defining jurisdictions and responsibilities.
3. Delegating authority.
4. Informing each worker of his function and to whom he is responsible.
5. Making each worker responsible to not more than one person for his major function.
6. Reducing to a minimum the number of people reporting to any one administrative officer.
7. Indicating interdepartmental and intradepartmental relationships; the individuals who should determine interdepartmental and intradepartmental policies and procedures, as well as representation on management and administrative committees.
8. Providing specific details for the evaluation of the worker on the job.

The chart, "Basic Organization for a Hospital Nursing Department," is developed to meet the foregoing criteria. It illustrates vertical lines of authority and horizontal coordinated interdepartmental relationships.

The "nursing team" concept for direct nursing care is represented through the delegation of responsibility and authority to the staff nurse for the work of the nonprofessional nurse.

CHART CAN BE MODIFIED

This organizational chart may be modified to meet the needs of the small hospital with less subdivision of service. Combinations of assistant directors (for example, medicine and surgery) may be made in terms of the hospital program of services. It may be expanded for the large hospital by indicating other possible subdivisions of clinical specialties.

An organizational chart developed on the basis of functional activities will evolve from a detailed analysis of each position represented on the chart. Such a functional analysis becomes a job description. It is a basis for job classification, rating and evaluation. Similar analyses should be developed and known by all concerned for each category of employe in the nursing department.

In summary, the organization of the nursing department in a hospital on a functional analysis of the job to be done, with clearly defined responsibility and authority, based on the premise that all activities are carried out to support direct nursing service to patients will aid in achieving the primary function of the department—consistently good nursing care to patients.

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[3]Council on Medical Education and Hospitals: Hospital Service in the United States. J.A.M.A. 143:34 (May 7) 1949.

[4]Practical Nurses and Auxiliary Workers for the Care of the Sick. Prepared by N.A.C.C.N., A.C.S.N., N.A.P.N.E. New York, 1947.

[5]Ibid. page 6.

[6]Bradenburg, Viola: A Functional Analysis of the Nursing Team Assignment. Washington, D.C.: The Catholic University of America Press. 1949.

[7]Jones, Elizabeth, and Ellsworth, Joan: An Experiment in Team Assignment, Am. J. Nursing, 49:146.

[8]Practical Nurses and Auxiliary Workers for the Care of the Sick. Prepared by N.A.C.C.N., A.C.S.N., N.A.P.N.E. New York, 1947.

Patients who live in GLASS WARDS *like them very much*

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OPEN wall glass construction is very popular with us here at Royal Newcastle Hospital, Newcastle, N.S.W., and I feel that it will be incorporated in all future designs of our hospitals.

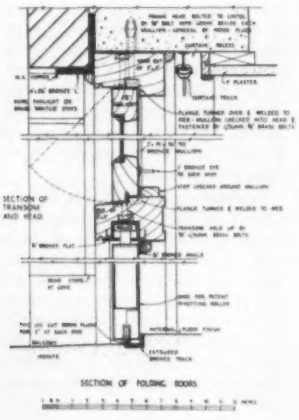
It has had a thorough trial over some years in two ward blocks and has proved successful. In one pavilion the doors were closed on only three days of last year, despite occasional very heavy weather.

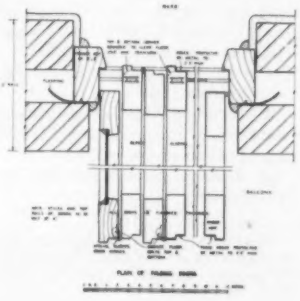
There appear to be two essentials to success in the use of this design:

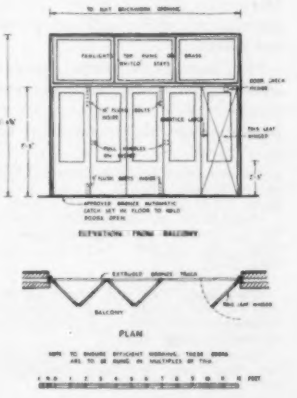
1. Verandas.
2. The wall in which the doors are placed must face the right quarter. In our particular area, it is impossible to employ design of this type on the south or southeast wall of a building. All our heavy weather comes from this quarter. It is most desirable to face a building either east or northeast.

The patients find these opened up wards much more attractive than the more usual type of construction.

It is our feeling that this design is extremely helpful in ensuring adequate ward ventilation. The interest aroused in recent years on the subject of ward cross-infection makes this a point of some importance. The use of this design plus terrazzo floors will, in our opinion, help considerably in eliminating this hazard.







how to translate

ACCOUNTS RECEIVABLE *into* ACCOUNTS RECEIVED

DAVID E. OLSSON
Assistant Manager
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San Jose, Calif.

IN MARCH 1949, the San Jose Hospital management decided that the time had come for drastic action on the steadily rising curve of patients' accounts. Too many people owed the hospital money and collections were lagging. What should—and could—be done about it?

Meetings attended by all personnel involved in the collection of accounts were held to obtain ideas, and from these discussions a system emerged. Those of our people who helped develop our new plan of procedure are rather proud of it and enjoy working with it. And the fact that the people who work with it had a part in developing it undoubtedly has been a factor in its success.

DIVIDED ACCOUNTS INTO SECTIONS

Because of the large number of accounts, we decided to divide them for better handling. We made up three ledgers or files; the first was the "In House" file, second, the insurance (Blue Cross, California Physicians Service, State Compensation), and third, personal collection, outside collection and litigation. Each file was placed in charge of one person. Together with all credit information that was written on the ledger card for an account in one of these three files, the person responsible was to receive all correspondence and any inquiries or information concerning the account. We had found that, often, patients or relatives coming in to discuss financial arrangements for payment seemed to be playing one of our employes against another by coming in the morning one time and in the evening another, with resulting confusion and delay.

After setting up the accounts in these three sections, we worked out a plan of monthly analysis by means of which we could explain to the administrator, the board of trustees and others interested in the condition of our accounts receivable just what the total figures actually meant. Even more important, it gave us an over-all view of our strong and weak points and enabled us to vary our attack accordingly. One of the accepted rules for judging whether total accounts receivable are excessive is to compare them with gross monthly charges. To obtain comparative data we went back into the records about 10 years, computed a yearly average and from this were able to show a monthly average. We derived some cold comfort from the fact that the ratio in 1949 was more favorable than at any time except during World War II; also, the increase in delinquent accounts could be at least partly justified by a corresponding increase in total business.

This type of weak-kneed justification was no solution to our problem, however. Therefore we kept plugging away and we finally came forth with the following procedure: As we balance the accounts to our general ledger at the end of the month, we make the entries in the three sections heretofore mentioned. By comparing the figures of the more recent months we find what is going up or down and what remains static. Actually, in our report analysis we go a little further in the sections and indicate on our tapes, or by separate tapes, a number of other breakdowns. These are In House, Blue Cross and Blue Shield, Other Insurance, Compensation, Litigation and Liability, Outside Collections and Personal Accounts.

The handling of all except In House and Personal Accounts is really only a billing procedure. Our chief concern is to satisfy the wants of the various companies, get this information to them as quickly as possible and thus give them no reason for delay in reimbursing us. This situation has been improved by giving attention to the closing-out date in order to receive payment by the end of the current month. The follow-through on this consists of tabulating the accounts processed by the aforementioned date and comparing this list with the checks received at the end of the month. Thus, we are able to correct our errors and keep the insurance companies working closely with us.

CHECK "IN HOUSE" FILE

We have found, however, that at times special analysis is needed in the In House file, so periodically we run a tape on this section and check those accounts that are to be paid personally, those that are compensation cases, and those covered by other types of insurance. We realize that our most difficult job is with personal payments so we give them special attention.

In handling these Personal Accounts we run a tape every six months, segregating them according to age: one month, one to two months, two to three months, three to six months, six months to a year, and more than one year.

As an example of what we have found by isolating our accounts in these sections, we soon discovered that faulty handling of Blue Cross and Blue Shield was a factor in our accounts being up. We called a series of meetings to discuss the problem and uncovered several errors in our procedure. We found that some statements were

being returned to us for correction or added information. This was traced to errors of the new personnel. In other words, the method of filling out certain forms had not been properly explained. After a month or so we were able to see substantial results, the balance on the books at the end of the month being cut almost in half.

ATTACKED WEAK SPOTS

Thus, in brief, by analyzing our problems and attacking the weak spots one at a time, rather than a scattered guesswork attack upon the whole system at once, we have obtained results. In our report, we comment upon the sections separately and show our plan of attack on the weak spots.

"'In House' figure for the month of February 1950 over January has increased approximately a thousand dollars, which, of course, it is natural to expect owing to increase in our gross charges. We have had a meeting on the subject of 'Payments Upon Admission,' to obtain more payments upon admission wherever and whenever practical. In addition to the foregoing, arrangements have now been set up whereby, when a patient has been discharged without satisfactory arrangements having been made, this information will be submitted to the doctor in the case, with request for suggestions as to how we will work together in order that arrangements may be made for payment of the bill.

"We have issued instructions that billings for Hospital Service Insurance (Blue Cross) shall be mailed out special delivery at least two days before the established deadline date in order that they may be properly processed for payment and anticipated inclusion with their remittance following this deadline date. We are hopeful that with this added procedure, we may be able to have a number more included with an earlier remittance by Blue Cross, rather than be delayed for at least two weeks because of failure to be received in time for processing.

"Owing to the severity of the collection problem facing us today, we have deleted our older accounts outstanding 90 days and longer and have turned them over to our collection agency, and it is hoped that a healthy recovery may be secured from a majority of these accounts by such further efforts to effect settlement.

"Regarding our litigation accounts, there apparently are a number of our cases which should be nearing the top on the court calendar for trial, and we are presently communicating with the local attorneys involved in many of these cases in an effort to determine the status of some of our litigation cases."

Further, at the end of our report we show the amounts collected in the four different sections, these totals serving somewhat as a measuring stick of the success of the collection efforts of the respective people handling the sections.

Our collection routine is set down in our manual. We stress, however, at the beginning that for obvious reasons the outline cannot be strictly adhered to, but rather is for general instruction of our personnel. Specific circumstances determine our action in each case and wide discretion is given the patients' accounts personnel. In keeping with this, we give these staff members the title of "patient account supervisors" so in their dealings with the public they are raised in esteem. By not using the title "credit manager" we avoid the suggestion of credit and cut down openings for requesting credit.

When their finances are tight people usually want to see the manager or assistant manager, hoping for some reason that this person will be less strict. The new title of "supervisor" seems to carry enough weight to discourage this; at any rate, there are fewer cases referred to that "soft touch," the assistant manager, much to my relief.

FOLLOW REGULAR PATTERN

Our contacts with patients and their relatives seem to hold to a fairly definite pattern despite attempts at variation. We try to prepare patients before they reach our admitting office by supplying the doctors with preadmission folders which explain, in addition to reminders about bringing slippers and so on, the financial arrangements and why we find it necessary to ask for a deposit upon admission. We make the approach in the folder as painless as possible, even to the loophole that if a prospective patient cannot pay the deposit he should come in and discuss the matter with our patient account supervisor.

Properly handled, we feel that these preadmission folders would be very helpful, but honesty compels me to say that many of the doctors are too busy or too forgetful to use them. Consequently, at the admitting desk the reaction of a majority of the patients when queried about the preadmission folder and the advance deposit is simply a blank look and a negative shake of the head. "No, I've never heard about that." So we are right back in the old routine, starting from scratch with the usual explanation.

ARRANGEMENT MUST BE DEFINITE

If the patient and/or relatives cannot pay the advance deposit, they are sent to the patient account supervisor, who then works out with them a schedule of payments or arranges for use of a bank plan. If no satisfactory arrangements can be completed we either, first, contact the relatives for payment, second, contact the doctors, third, get a credit bureau report, and fourth, if it is so determined, set the case up for charity assistance.

If no payments are received at the time of discharge or if there is a debit balance, we collect the amount due or make full credit arrangements with the person who will from this point handle the account. No one leaves without a definite arrangement as to how his bill will be paid. Then the person handling the Personal Accounts section sets up his "tickler" file, showing the date upon which action is to be taken, and follows through if payment has not been received on that date. In some cases, of course, before the patient leaves the hospital we get a signed note or work out a bank plan.

Our collection efforts feature statements, telephone calls, letters (including special delivery), collect letters from the collection bureau, and telegrams. When all of our collection efforts have proved unsuccessful, the accounts are turned over to the collection bureau or, in a few cases, submitted to an attorney.

If at any point in our collection routine it turns out that further efforts on our part seem hopeless, we immediately send the account to the collection bureau. On the other hand, if even at the end of 90 days it appears there still is hope of success through our own collection department, we retain the account until all possibilities are exhausted.

(This article was written with some apprehension and, sure enough, as we had feared the current month saw the accounts rise a bit. However, we are quite sure we know just where to apply our efforts to bring them down again, which we will!)

FORMULA ROOM

has been redesigned for better use of space and greater efficiency

Previously washed bottles are loaded into the sterilizer.

IN APRIL of 1949, Mount St. Mary's Hospital, Niagara Falls, N.Y., opened its new milk formula laboratory. More than a year of successful operation has proved the wisdom of the change in this vital function of the hospital, namely, the care of the new-born infant's feedings in its first days in the hospital. The new equipment and method have proved satisfactory to the nursing personnel and the medical staff. They have facilitated in many ways the formula preparation for the newborn.

The former formula room was completely revamped. Instead of one large room, it was reconverted by a partition into two major divisions.

Receiving and Clean-Up Room (approximately 7 by 15 feet 6 inches)

This room is equipped and planned to accommodate from 200 to 300 bottles per day, and some consideration has been given for future expansion when indicated. The plan of segregating the clean-up area from the preparation room constitutes a practical and efficient arrangement for such a service.

The double door sterilizer makes it possible to establish an exacting technic which ensures presterilization of all cleansed supplies, such as nipples, bottles and utensils. This prevents the entrance of potentially contaminated equipment into the preparation room.

The equipment of the receiving and clean-up room consists of: stainless metal clean-up unit with open shelving under the receiving end, double sink, bottle washer, bottle rinser and storage cabinets under the clean section of the work counter. The sterilizer is of the rectangular type, double door construction, recessed mounted, extending through the walls into the preparation room.

Formula Preparation Room (approximately 10 by 15 feet 6 inches)

Ample space is an important factor in the efficient operation of any formula room. This allows for correct arrangement of work counters and appropriate equipment so that the important details of preparation can be accomplished without confusion.

Wherever space allows, it is always desirable to arrange for building in the sterilizing units. The advantages are obvious. It eliminates excessive heat from the formula room, promotes sanitation, and also minimizes the tedious work of daily cleaning and polishing of exposed surfaces.

Part of the equipment is the stainless metal portable bottle carriage, adjacent to the hand scrub sink. Its use is principally for the conveyance of bottles and utensils within the laboratory itself, as well as for the transportation of the prepared formulas to the various nurseries.

The superintendent of Mount St. Mary's Hospital conferred with a sterilizer manufacturer when a change in formula preparation was considered. Since the hospital is located in New York State, the Department of Health Sanitary Code, Regulation 35, "Precautions to Be Observed for the Control of Diarrhea of the Newborn," was taken into consideration.

Terminal sterilization method of formula preparation has proved satisfactory for many reasons, among them the precision and accuracy which ensure positive destruction of all communicable disease-producing organisms and provide a maximum protection against contamination in later handling of the formula.

In the "Manual of Sterilization, Disinfection and Related Surgical Technics" published by the research department of the manufacturer, a formula preparation technic is suggested. With a few minor adjustments it is followed in the preparation of the formulas in the new formula room at Mount St. Mary's Hospital.

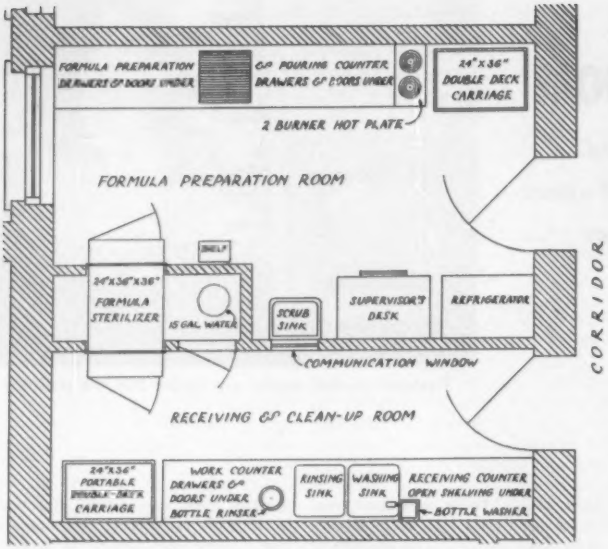
SISTER M. ISABEL
Administrator
Mount St. Mary's Hospital
Niagara Falls, N.Y.

FORMULA PREPARATION

Step 1. Before performing any duty in the formula preparation room the nurse should employ the conventional three-minute scrub.

Step 2. All bottles, nipples and utensils are to be thoroughly washed with hot soap suds or some other effective detergent, rinsed in hot water, and sterilized by pressure steam at 250 to 254° F. for a period of 10 minutes.

Step 3. Formula ingredients (milk, sugar or modifier, such as dextrin and maltose or corn sirup) and sterile



Plan of the milk formula laboratory showing the division of the two areas.

water should be placed in sterile containers, mixed and then transferred to previously washed sterile bottles. (Caution—Do not fill bottles beyond last graduated line, indicating maximum volume.)

Step 4. Sterile nipples are then attached to bottles and each nipple is completely covered with a previously sterilized paper cap, extending well over the shoulder of the bottle and held firmly in place with a rubber band. Label bottles and place in appropriate racks or carriers. (If paper caps are used, the infant's name or number can be written directly on the cap.)

TERMINAL HEATING OF FORMULAS

Feedings prepared with whole milk, skim milk, evaporated milk and/or water should be subjected to this process. Do not subject lactic acid formulas to terminal heating.

Step 1. Following preparation, the formulas are immediately placed in the sterilizer and subjected to nonpressure steam for 30 minutes at 210 to 212° F. (The period of exposure is timed when the thermometer indicates 210° F. in its advance toward the maximum.) Exposure continues for 30 minutes (no longer) after which the steam is turned off and the door opened immediately. (The usual 15 to 17 pounds' pressure should be maintained in the jacket of the sterilizer.)

Step 2. Remove formulas from sterilizer and allow to cool at room temperature for one to two hours. Finally, transfer formulas to refrigerator maintained at a temperature of 40 to 45° F. where they remain until feeding time.

FEEDING OF THE INFANT (NURSERY)

Step 1. At feeding time, the nurse with scrubbed and disinfected hands removes from the refrigerator a bottle of formula for each infant and places it in the bottle rack or carrier. The rack is then placed in the "bottle warmer" containing water at the correct level and allowed to remain there for a short period of time (15 to 20 minutes) until the formulas have attained a temperature of 100° F.

Step 2. The feeding nurse (masked, hands and arms scrubbed and disinfected) selects from the rack or carrier the formula labeled for the infant, checks and records the amount of milk in the bottle. Finally, the paper cap is removed from the nipple and the infant elevated for the feeding.

CARE OF BOTTLES

Immediately after feeding, rinse the bottles well with cold water. All bottles should then be returned to the clean-up section of the formula room and carefully washed in hot water containing some efficient detergent. The use of a bottle brush or preferably a mechanical washing unit to remove any particles of milk protein or sediment that may adhere to the glass is recommended. Rinse bottles thoroughly in hot running water (mechanical rinser), invert in stainless metal carriers and sterilize by pressure steam at 250 to 254° F. for a period of 10 minutes. After sterilization, bottles may be placed on preparation work counter and covered with a sterile sheet.

CARE OF NIPPLES

Remove nipples from bottles immediately after feeding and rinse inside and out with cold running water, followed by careful washing in hot water containing some efficient detergent upon return to the formula room. Rinse thoroughly with hot running water. Place nipples in muslin bag and sterilize by pressure steam at 250 to 254° F. for a period of 10 minutes. Longer exposure should be avoided.

CARE OF UTENSILS

Following completion of the formulas, the various utensils and containers used in their preparation should be delivered to the clean-up section of the laboratory for thorough washing, rinsing and sterilization. When utensils are loaded, large graduates, quart milk bottles, jars and other containers are inverted or at least rest on their sides, never in the upright position, otherwise sterilization will not be accomplished.

MISCELLANEOUS SUPPLIES

The same sterilizer used for terminal heating of formulas should be so adapted that it also can be utilized for the pressure steam sterilization of gowns, table covers, face masks, and other supplies common to the formula room and nursery. The recommended periods of exposure at a temperature of 250 to 254° F. for these various supplies are as follows:

Empty nursing bottles, always bottom side up, 10 minutes.

Nipples, in muslin bag, 10 minutes.

Utensils, spoons, measuring devices, 10 minutes.

Paper caps, loosely packed in perforated bottom, 10 minutes.

Rubber gloves in muslin wrapper, 15 minutes.

Water in 1000 or 2000 ml. flasks, 20 minutes.

Table covers and gowns in muslin covers, 30 minutes.

how to make the best use of

AUXILIARY PERSONNEL

LOIS M. HOWARD, R.N.
Supervisor of Auxiliary Personnel
Latter-day Saints Hospital
Salt Lake City
Utah

NONPROFESSIONAL hospital personnel had been used to a limited extent for some time prior to the wartime shortage of professional workers. Attendants and orderlies both worked at various assignments with "on-the-job training." It was not until the use of voluntary workers and attendants became widespread that formal instruction and supervision of this personnel group became the aim of the better hospitals.

Red Cross nursing classes for volunteers were started. Hospitals instituted class instruction of varying types and efficiency. As an end result of such instruction it was hoped to establish a program whereby the auxiliary employe could be used to the best advantage. We no longer debate the question of whether or not auxiliary personnel can be used in the nursing service program. The question at present is, "How can it be used efficiently and safely?"

ASSISTANT DIRECTOR'S DUTIES

In our 368 bed general hospital we are constantly striving toward a more satisfactory nursing service program and the proper utilization of the auxiliary group. The functions of the assistant director in charge of nonprofessional personnel are as follows:

1. To assist with the administration and development of a nursing service program as carried out by the auxiliary personnel, *i.e.* licensed practical nurses, ward clerks, attendants and orderlies.

2. To interpret to the auxiliary personnel directives originated by the hospital administrator and/or the director of nurses.

3. To assist in the maintenance of good morale and to promote harmony between the auxiliary personnel and other departments.

4. To plan and execute a training program.

5. To supervise and evaluate service given by the auxiliary personnel.

We have recently employed maids in the housekeeping department to take over duties previously performed by attendants. In the past, when the census was high, dirt accumulated as the amount of nursing service to be given increased. Only when the census was low did the departments receive proper cleaning. Time studies were made on busy days. This proved the necessity for the change and through the help and cooperation of the housekeeping department we were able to outline a list of duties for maids. This plan is working quite satisfactorily. Both the maids and the members of the nursing service understand the division of duties and are given detailed instructions which include the information shown in the lists of duties (see page 58) assigned to nursing service and to the housekeeping department.

In order to give our patients the best possible care there must be constant cooperation between the personnel of the nursing service and the housekeeping department. The maids and porters have been assigned definite duties and in order to fulfill their purpose these assignments are to be changed only through the head housekeeper. Unsatisfactory work observed by the nursing division is reported directly to the head housekeeper.

By following the program we find that the hospital is in presentable condition at all times rather than just when the patient load is low. It is not necessary to give the maid the hours of class work essential for the training of the attendant, thus making it a more economical program.

For 18 months we have used ward clerks and have found them to be indispensable. Head nurses are freed from detailed paper work and are able to spend more time at the patient's bedside. Ward clerks are trained to relieve the head nurse of routine clerical duties and work under the supervision of the registered nurses. Their duties are shown in the chart on page 58.

The attendants are prepared to care for subacute, convalescent and chronic patients and to assist the registered nurse in the care of others. They carry out duties necessary for the support of nursing service including the duties which involve minor service, such as errands and cleanliness of the divisions. They work under the supervision of the registered nurse. Their duties are listed on page 58.

Orderlies are male employes whose functions are the same as those of the attendants, plus the catheterization of male patients.

CLASSES FOR ATTENDANTS

The attendant group constitutes the largest percentage of our auxiliary personnel and a training program has been worked out for it. Classes are held for this group of employes and a salary increase of $5 is given monthly for three months if their work is satisfactory. Another $5 increase is given at the end of six months if they continue to perform their duties satisfactorily.

Unsatisfactory efficiency reports are discussed with each employe. Frequently a transfer to another department is indicated, but two successive unsatisfactory reports are considered sufficient reason for the dismissal of the person, which is done by giving two weeks' notice. An effort is made to transfer an employe to another de-

CLEANING DUTIES ASSIGNED TO HOUSEKEEPING DEPARTMENT

- Care of ceilings, walls, mopboards, floors and doors
- Care of venetian blinds
- Care of windows and radiators
- Care of toilet bowls
- Care of all lavatories
- Care of drinking fountains
- Care of porches and lounges
- Care of shades and draperies—chair covers and upholstery
- Care of wastebaskets
- Care of closets, shelves and cupboards
- Care of patients' flowers
- Care of departmental kitchen, utility rooms, treatment room, bathroom, hopper room, linen room
- Care of all wash bowls and mirrors
- Storage of linen coming from laundry
- Care of wheel chairs and stretchers
- Care of unit curtains and screen covers
- Care of glass partition and partition curtains

HOUSEKEEPING DUTIES (Cont.)

- Care of unused side boards
- Cleaning of the vacated unit

CLEANING DUTIES ASSIGNED TO NURSING SERVICE

- Care of standards
- Care of oxygen tents
- Care of all orthopedic equipment
- Care of enema trays and cans
- Care of rectal tubes and catheters
- Care of mop cans and amphyl solution
- Care of dressing cart
- Care of medicine cupboards
- Care of arm boards
- Distribution of clean linen
- Making of other bundles, paper bags, paper cups
- Storage of sterile supplies
- Errands as needed
- Prepare vacated unit for new patient (Strip unit; clean and sterilize the equipment. Make up the bed and see that the unit is ready for the new patient.)

DUTIES OF WARD CLERKS

- Ordering linen and various other supplies
- Sorting and distributing mail
- Storing supplies
- Charting temperature, pulse and respiration
- Labeling and delivering specimens to laboratory
- Checking diet cards
- Preparing charts for discharge
- Passing and collecting selective menus
- Preparing daily census report
- Preparing daily supervisor's report (condition of patient to be filled in by supervisor)
- Making up new charts and medicine cards
- Replenishing charts with new sheets as needed
- Cleaning chart room
- Preparing daily time sheets
- Preparing daily temperature sheet
- Preparing weekly hour book
- Copying weekly time sheet
- Taking patients to front office for discharge
- Making out charts for newly admitted patients
- Making bed identification tags for newly admitted patients
- Filing surgical records, laboratory slips
- Checking charts for histories
- Signing employes on and off duty
- Cutting scratch paper

WARD CLERKS' DUTIES (Cont.)

- Cleaning chart backs
- Answering telephone
- Making necessary phone calls for patients
- Errands to various divisions and departments as designated by the nurse in charge

DUTIES OF ATTENDANTS

- Serving trays—feeding helpless patients
- Recording intake and output
- Cleaning and making up units after discharge of patient
- Bed making: unoccupied bed, occupied bed, anesthetic bed and oxygen bed
- General routine care of patients: bed baths, tub baths, back care, mouth care, morning and evening care
- Getting patients up in a chair
- Care of instruments, rubber goods and rubber gloves
- Admission, transfer and discharge of patients
- Care of body after death
- Taking temperature (oral, rectal, axillary)
- Taking pulse and respiration
- Placing of hot water bottles and ice caps
- Giving cleansing enema
- Cleaning of oxygen tents, standards, orthopedic equipment, enema trays and cans, rectal tubes and catheters, dressing carts, medicine cupboards

DUTIES OF LICENSED PRACTICAL NURSES

- Attending nurse report
- Charting T.P.R., giving nursing care, and recording symptoms
- Catheterizing patients
- Preparing and giving simple oral medications
- Administering rectal medications as directed
- Applying hot stupes
- Giving throat irrigations
- Assisting physicians with physical examinations and the changing of dressings
- Taking and recording blood pressure
- Changing colostomy dressings
- Caring for isolated patients
- Giving temperature sponge baths
- Assisting with special procedures, i.e., spinal punctures and so on
- Dressing decubitus as directed
- Inserting rectal and vaginal suppositories
- Caring for patients recovering from anesthesia

partment at her request. Such consideration has saved us several valuable employes who might otherwise have resigned.

The classes for new employes consist of formal lectures, demonstrations and return demonstrations and are held on hospital time. Forty hours of class instruction, covering the following subjects, are given:

A thorough review and explanation of our personnel policies.

The meaning of ethics and its importance in a hospital.

The purpose of auxiliary personnel.

Personal hygiene.

The importance of efficiency records.

Feeding the patient, *i.e.* the serving of the tray and feeding the helpless patient.

The importance of recording intake and output.

The care of the division kitchen and utility rooms.

The care of patients' plants and flowers.

Cleaning and returning a unit to order after the discharge of a patient.

The importance of quiet, proper lighting and ventilation.

Bedmaking: the unoccupied and occupied bed, the anesthetic bed and the oxygen bed.

The method of placing a bedpan and the importance of accurately reporting its contents.

The care of the mouth and teeth.

The care of the mouth of the very ill patient.

The morning care of the patient and his room.

Evening care.

Bed sores, their symptoms, causes and prevention.

Procedure for routine back care.

Changing the patient's gown.

Cleansing baths.

Getting a patient up in a chair.

Preparation of supplies for sterilization.

Sterilization of utensils.

Preparation of instruments for autoclaving.

Care of rubber goods.

Care of rubber gloves.

Admission, transfer and discharge of patients.

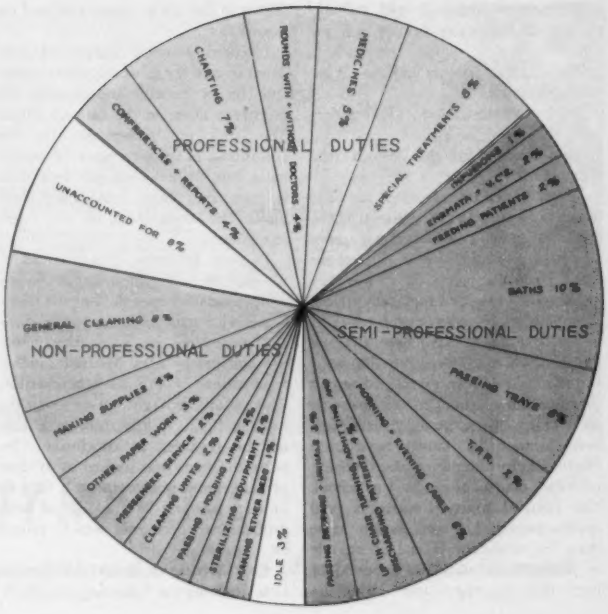
The transporting of patients by stretcher.

Death and the care of the body after death.

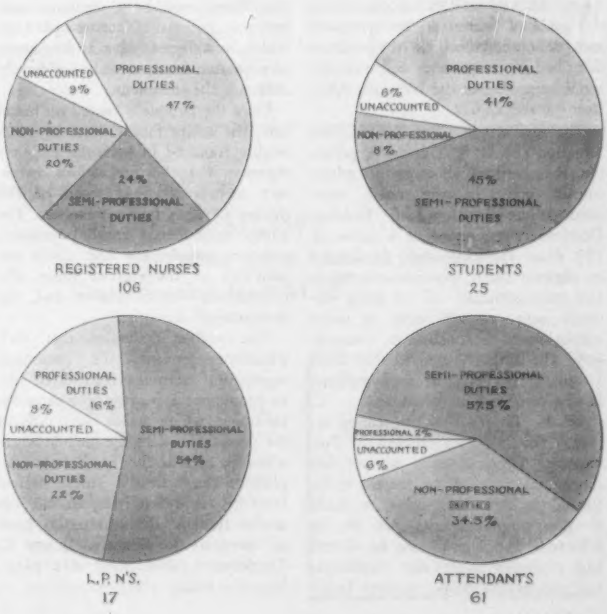
Pulse and respiration.

Temperature: oral, rectal, axillary.

The importance of observing symptoms and accurately reporting them.



Above: This graph shows that of all duties performed 29 per cent of the time was spent on those of a professional nature. Below: How time was spent by registered nurses, students, practical nurses, and attendants.



The use of heat and cold and the placing of hot water bottles and ice caps.

The cleansing enema and the oil retention enema.

Male catheterization (for orderlies).

The cleaning of the oxygen tent after use.

When classes are completed the head nurse is given a list of duties that the attendant is allowed to perform under supervision. Supervision throughout the division is given daily. Monthly meetings are held and suggestions from the employes are encouraged.

Practical nurses have been licensed in our state and we have the good fortune of having an excellent licensed practical nurse school in our immediate vicinity. Most of those who have been licensed by waiver have been interested in attending the evening refresher course given by the school. The licensed practical nurse is paid approximately $20 per month more than the attendant if she is capable of performing the duties expected of her. Her functions and duties are shown in the list of duties outlined on page 58.

Licensed practical nurses are prepared to care for subacute, convalescent and chronic patients and to assist the registered nurse in the care of others. Too, they are responsible for the cleanliness of certain types of equipment but the majority of their time is spent in patient care. They work under the supervision of the registered nurse.

Because we were concerned as to whether we were employing too many nonprofessional people on the nursing service staff, a time study of nursing procedures was made throughout the hospital by Mrs. Mildred Lindley, head nurse of the medical division. This study brought many startling facts to light. While these facts cannot be regarded as conclusive (because the study was limited as to time, personnel and interpretation), they do indicate a trend in the use of nonprofessional personnel which cannot be ignored.

Our nursing staff, at the present time, includes the following personnel:

Head nurses and supervisors	12 per cent
Staff nurses	32 per cent
Students	17 per cent
Auxiliary personnel	39 per cent

The time study made by Mrs. Lindley covered 106 registered nurses, 25 students, 17 licensed practical nurses, and 61 attendants.

A survey of patients' call lights showed that only 17 per cent had to be cared for by nurses while the remaining 83 per cent could be cared for by the auxiliary personnel.

A survey of telephone calls showed that 19 per cent had to be cared for by nurses while the remaining 81 per cent could be cared for by auxiliary personnel.

Approximately 53 per cent of the nurses' time was spent performing duties which could have been handled by auxiliary personnel. This percentage was higher in the obstetrical department than in any other division (average for obstetrical division, 64 per cent).

The four small graphs show how the time was spent by 106 registered nurses, 25 students, 17 licensed practical nurses, and 61 attendants.

Of the total working hours covered by the time study, 55 per cent of the time was spent by registered nurses; 11 per cent of the time was spent by students; 7 per cent of the time was spent by licensed practical nurses, and 27 per cent of the time was spent by attendants.

The large graph shows that of all duties performed 29 per cent of the time was spent on those of a professional nature. Knowing that 55 per cent of the working hours were spent by the professional nurse we readily see that our ratio of nonprofessional help is not too high. Of the duties performed, 35 per cent of the time was spent on those of a semiprofessional nature and 36 per cent on those of a nonprofessional nature.

Our program for the use of auxiliary personnel has a long way to go to meet the increasing requirements which the graphs indicate are necessary. We do believe, however, the first step has been taken, that is, the recognition of the rôle that such auxiliary workers play and will continue to play. We hope to improve our supervision and instruction to allow us to use this group of employes to full advantage without sacrificing what is best in nursing service within our hospital.

Home Care for the Tuberculous

AN ADAPTATION of the principle of home care to the treatment of tuberculosis in England is described in two articles and one editorial appearing in the Nov. 19, 1949, issue of the *Lancet*.

The first article, "The Tuberculosis Situation" by H. J. Trenchard, points out the perilous shortage of tuberculosis beds in the north west metropolitan section of London. Domiciliary treatment of a series of 153 cases included such procedures as phrenic crush, pneumoperitoneum and pneumothorax; 27 of these patients improved sufficiently to make admission to a sanatorium unnecessary. The author estimates that from 10 to 25 per cent of such patients can be cared for in the home.

W. H. Tattersall in the second article, "The Home Treatment of Pulmonary Tuberculosis," warns that careful selection of the patient to be treated in the home must be made if the proper results are to be achieved. The home must be visited and evaluated as to size, cleanliness and presence of proper sanitary facilities. There must be a separate room for the patient. Close cooperation with the welfare officer is important so economic factors will not adversely influence the treatment.

Once the patient is placed on home care, the entire family must be thoroughly educated in both the patient's regimen and the precautions necessary to prevent the spread of the disease to other family members. The author recommends weekly physician's visits to supplement and direct the activities of the district nurse, the tuberculosis health visitor and the occupational therapist.

The author maintains that such treatment prevents the prolonged segregation from the realities of life, so prominent a feature of sanatorium treatment, which makes more difficult the necessity to face the outside world when the organic cure has been accomplished. The benefit a patient derives from his family's rallying around him at the time of illness often is itself an incentive to recovery.—JOHN D. THOMPSON, *Montefiore Hospital, New York City.*

GADSDEN COUNTY HOSPITAL

has been designed with ease of maintenance in mind

A. P. ALMOND
Vice President
Robert and Company Associates
Architects and Engineers
Atlanta, Ga.

QUINCY, FLA., is the county seat of a fine agricultural area mainly producing tobacco. The existing hospital in Quincy is a remodeled residence of wood construction housing approximately 25 beds. This has proved entirely inadequate and out of date and the people of Gadsden County, acting through the board of directors of the Gadsden County Hospital, desired to take advantage of the Hill-Burton Act funds to construct a hospital in keeping with the community. The board of directors wished to provide at this time a hospital with approximately a 70 bed capacity so arranged that it can be expanded to 100 beds but with little or no increase in cost included for facilities which may be sufficiently large for the expanded hospital.

It was also desired to keep the cost of the hospital to a minimum and still provide for a good workable layout and a selection of materials and finishes that will not require excessive maintenance.

The property was a gift to the county for hospital purposes. It lies in a north-south direction with the north end of the lot adjoining a main through thoroughfare. The prevailing breeze is also from the southwest especially during the summer months. The hospital building was, therefore, located on the site with four considerations in mind. (1) It was placed back as far as possible from the high traffic thoroughfare and the end was placed toward the street to eliminate as much traffic noise as possible. (2) The building was placed on the site so the patients looking out of their rooms would see nicely landscaped areas away from the main thoroughfare. (3) It was important to place as many rooms as possible on the southwest side to get the prevailing breeze. (4) It was necessary to place the building as economically as possible because this site is somewhat rough.

The hospital is close to the center

Project Cost: $791,131

Cost per bed: $11,465

(including group I and II equipment)

Cost per cubic foot: $1.55

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

of population and close to the hotels. Its closeness to the hotels was thought to be an advantage by the board of directors inasmuch as the hospital is used by the whole county and relatives can stay in the hotels.

The hospital will serve the entire county, which has a population of approximately 30,000. However, about 5000 are in the state neuropsychiatric institution and should not be counted in estimating the requirements of the hospital.

Especial attention has been given to compactness and ease of operation. The central sterile supply has been located adjoining the surgery so that the surgical nurses can supervise this department. No necropsy room has been provided because Tallahassee is some 21 miles away and it was thought by the doctors and the board of directors that it would be preferable to do the necropsy work in the large hospital in Tallahassee where a pathologist would be available.

HOW SPACE IS ALLOCATED

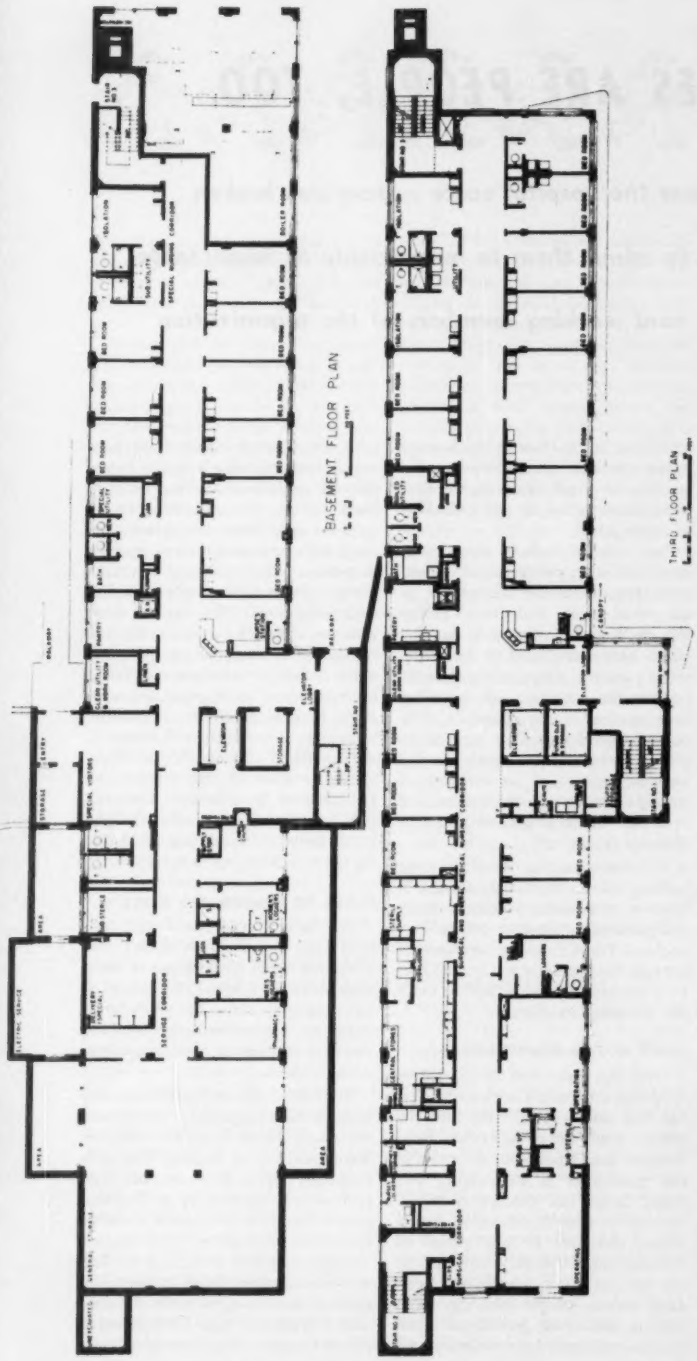
The basement floor, which is actually the ground floor, has been mainly devoted to special patients. The first floor is used for the administrative area, kitchen and services, emergency and outpatient department. The second floor is devoted to delivery and maternity and general medical beds. The third floor houses surgery and surgical and medical beds.

Especial attention has also been given to the selection of proper institutional materials so as to hold down excessive maintenance cost, which is most important in hospital design. The windows are an awning type which can be left open during fairly heavy rains and which we think is most desirable, particularly in warm climates. On the west side concrete canopies protect the windows and walls from the sun.

It was decided by the board of directors that no laundry would be provided at the hospital at this time because there are several good commercial laundries in the city. If this condition changes and, in any event, if future additions are made to the hospital, a laundry can be added in the basement of the future addition.

Many of the operative cases in this area have been going elsewhere because of the lack of facilities. This hospital has been designed to render a complete service and we believe it will fulfill the needs of the community.

Floor plans of Gadsden County Hospital. Below: The first floor is used for administrative, kitchen, emergency and outpatient departments. Opposite Page: The basement (or ground floor) houses special patients. Surgery is on the third floor. The second floor (not shown) contains the maternity and delivery departments and general beds.



CONSTRUCTION DETAILS

Gadsden County Hospital
Quincy, Fla.

STRUCTURE: Reinforced concrete, structural steel frames with bar joist, concrete floors and roofs.

WALLS: Reinforced concrete, hollow tile and brick. Majority of interior walls are clay tile plastered. Some of the walls in service areas are structural glazed tile.

ROOF: Built-up roof with tar and gravel, 1 inch rigid glass fiber insulation over lightweight concrete fill. This is a double "A-A" 20 year roof.

FINISHES: Conductive terrazzo floors and terrazzo base in all operating rooms, scrub-up room, labor rooms, delivery rooms, substerile rooms, obstetrical corridors and surgical corridors. Ceramic tile wainscot in all pantries, toilets, bathrooms, soiled utility, and all service rooms. Ceramic tile wainscot 7 feet high in surgery and delivery suites. Rubber tile floor and base in remainder of corridors. All bedrooms and wards, asphalt tile floors, rubber tile base. Vinyl plastic wainscot in all main corridors, lobbies and waiting rooms; plaster walls and acoustical ceilings. Bedrooms have plaster walls and ceilings. Quarry tile floor and structural glazed tile wainscot in all kitchen areas.

WINDOWS: Hospital awning-type steel windows with precast concrete sills, metal and tile stools, double glazing in operating, delivery and all air conditioned rooms. Entire building equipped with venetian blinds.

DOORS: Flush metal exterior doors. Interior doors, flush panel, solid core wood veneer doors.

INTERCOMMUNICATING SYSTEM: The entire building equipped with nurses', patients' and doctors' intercommunicating system.

HEATING: Steam heating with modified convector type of radiation generally and unit heaters in storage and other similar spaces. Boilers are oil-fired operating at 125 pounds with reduced pressures for the heating and process systems.

AIR CONDITIONING: Air conditioning is provided in labor, delivery and operating rooms. It is designed for temperature and humidity control, two central station air conditioning systems using freon 12 as the primary refrigerant and chilled water as the secondary refrigerant. System will handle 100 per cent outside air which will be conditioned, delivered to the rooms and then exhausted to the out-of-doors.

A special feature is the means of distribution of air to these rooms which is accomplished by multi-vent air distribution outlets providing draftless conditions at the breathing level. Pneumatic temperature and humidity control.

VENTILATION: Exhaust is provided for the main kitchen by individual fans located on the roof of the building; fume hood in laboratory. General supply ventilation of tempered air is provided from three air handling units to care for all other areas.

SUMMARY: Total project cost, including all fixed equipment, $791,131. Cost per bed, including fixed equipment, $11,465. Total square foot area, 41,597 square feet. Total square foot area per bed, 602 square feet. Cost per square foot based on total cost of building, $19. Total cubic feet, 509,934. Cost per cubic foot, $1.55.

ORDERLIES ARE PEOPLE, TOO

and it is time the hospital caste system was broken down to admit them to membership as respectable, hard working members of the organization

REGARDLESS of the fact that his tasks have been called "menial" (and who has made that distinction?), the rôle an orderly plays in the hospital is important both to the hospital and to its major concern, the patient. He is important to the hospital because in the correct performance of his duties he helps maintain the high standards of efficiency and reliability necessary for its proper functioning. His importance to the patient lies in being cheerful and reassuring and attending to the patient's needs until that blessed day when he has fully recovered and is ready to resume a normal life.

CAME FROM DUBIOUS BACKGROUND

A decade ago the hospital orderly could be acquired from a shady employment agency. No attempt was ever made by the hospital personnel director to inquire into his background, moral character or work experience. Seldom, if ever, was he asked what his own personal feelings toward the sick were. The hospital had need of him to perform those objectionable tasks the nursing profession refused, and he filled that need—at 30 or 40 dollars a month.

Typical of the orderly during this period were the drifter, the unsuitable, the chronic alcoholic, the drug addict, and the petty thief. Yet hospital administrators tolerated him because he filled their need. He might breathe alcoholic fumes into the faces of the patients he dealt with daily, but again the hospital found it practical to retain him because, as labor, he was a cheap commodity.

Today, in almost all hospitals, the orderly is meted out the same identical treatment, because somehow a misinformed public has identified his job with that of the comic Hollywood screen character. His proficiency as a member of a self-sacrificing medical team succoring the ill and bedridden is unrecognized.

The hospital orderly along with other subsidiary workers has indeed been relegated to the background in the public mind. And instead of being made to feel that their humble efforts have contributed to the recovery of a patient, nonprofessional workers face the notorious and degrading caste system in our hospitals. The casual hospital visitor, or the outside observer, would be profoundly shocked were he to learn of the existence of employe caste systems in America's institutions. The following will serve to illustrate this system.

A few years ago in one of the large training schools for nurses located in the East, an assembly of student nurses had gathered to hear a lecture on "Professional Ethics"; during the course of her talk, the instructor was quoted later by a student auditor as having made the following statements:

DON'T BE TOO DEMOCRATIC

"Nursing, more than an art, will be for you in the future a noble profession, one that carries with it the love and respect of millions of Americans. Here, however, may I point out the ethics of our profession is democratic, but, young ladies, our conception of democracy must never descend to demoralizing elements. In your period of training you will work with people on the hospital floors, laboratories, operating rooms—people who can never hope to achieve the professional status that you will some day tenaciously hold.

"These nonprofessionals I speak of —I illustrate by using a typical example, the 'orderlies.' Let me be very frank and say we consider them 'a necessary evil.' Your consideration for them and contacts with them must be in terms of their potential worth as workers, and not individuals to become sentimental over. You may ask them what you wish to have done in the way of work procedures; however, you are not to fraternize with them, specifically make no dates or engagements with them. Professional ethics considers the association of any nurse with personnel not considered professional a detriment to the welfare of the hospital, an anathema to be avoided. After all, girls," the instructor concluded, "you would not want to tell your child that his father was only an orderly."

FAILED TO COMPREHEND NEEDS

The injustices associated with hospital caste systems have found root where the moral imaginations of those responsible for hospital administration and nursing education have failed miserably to comprehend the interests, needs or feelings of their nonprofessional workers.

The ethics, rules and regulations that hospitals have employed to incite caste systems can hardly honor the humanity and scholarship of nursing. The contemporary approach to subsidiary nonprofessional employes in general and mental hospitals is to treat them as convenient ignoramuses. That the values and supposed virtues of nursing school ethics have failed to reach the hospital ward is apparent in the conduct of those who regard themselves as the professional dispensers of nursing

The authors are orderlies employed in a New England hospital.

care. If ethics is an integral part of the nursing program and if the definition of ethics is "a code of morals and conduct," then the ethic itself has been lost.

In all probability there is no greater power on earth than the power to heal sick minds and bodies. Mere words cannot begin to describe the gratitude and admiration felt by patients who have been restored to health for those who have the knowledge and power of healing. To hear patients humbly thanking doctors or any and every one connected with hospital work for their treatment and recovery is indeed gratifying. Is it, then, too presumptuous to believe that the better the care a patient receives the faster will be his ultimate recovery, and should one conclude that the best care can be given him only when there is absolute unity and cooperation from the entire hospital body? We think not.

CANNOT EXPLOIT PERSONNEL

The main interests and responsibilities of a hospital as a unit are (or should be) the care, treatment and welfare of its patients. How are patients to receive the best care if there is discontent among the personnel? And how are we to have complete unity if the administration continues to advocate the practice of a caste system whereby the majority of the personnel is exploited for the benefit of the hospital?

Orderlies are as necessary to a hospital as are the doctors, janitors, nurses, maids and dishwashers. Each has a duty to perform which must be done to ensure the proper functioning of that institution. Is it fair to the orderlies then to look upon them as "just orderlies" or "just attendants," and make them feel that they are there merely because there is some heavy, disagreeable or dirty work to perform and therefore they must be tolerated?

Day after day, these same men work beside doctors and nurses but at mealtimes in some hospitals they are relegated to a small hole in the basement to be fed in an atmosphere reminiscent of Dickens' London workhouses. And in some hospitals that offer living facilities, the accommodations are little better, and sometimes worse, than a Bowery flophouse. Constantly reminded that he is "only an orderly," he finds himself blacklisted from any social engagements with nurses. Indeed, the training schools for nurses attached to many hospitals make it quite clear to their students that any fraternizing with orderlies will lead to their dismissal from training. But whether this attitude on the part of the administrative body of the hospital is due to ignorance, lack of judgment or absence of ethics is not the really important point.

What is important is this: Should men who work in private or public hospitals as nursing or operating room orderlies, who receive neither social security benefits nor pensions, and whose jobs are jeopardized by lack of organization remain silent in face of a caste system that is diabolically cruel? If orderlies who are considered good enough to work beside doctors and nurses on wards, in laboratories and operating rooms become pariahs at mealtimes, after hours of duty, and on the street, then hospitals have no right to consider themselves humanitarian institutions.

NOT REGARDED AS EQUALS

Modern hospitals, it seems, do not take into account the fact that their nonprofessional employes are human beings. They do not look on them as their equals and the handiwork of God, but rather as puppets, manipulated not by dextrous fingers but by terse commands. They regard them not according to their thoughts and deeds, minds or bodies, but according to their potential "worth" as "workers." Most hospitals cosider not how *much* they *should* pay them, but how *little* they *can* pay them.

The opinions of the medical profession regarding this "caste system" are exemplified in statements such as this: "If you don't like it here why don't you quit?" Or another equally asinine remark: "If you could do better elsewhere you wouldn't be here." Heaven help us, for if these are the people we have to deal with (and it certainly seems that way) we will surely need help. Words of this sort have the same effect on some of us as a surgeon's scalpel would have on an unanesthetized patient.

Anyone of average intelligence can see that employes who leave one organization to find a job in another because of disagreement or dissatisfaction at their treatment as human beings will never accomplish anything. True, one may find peace and satisfaction in a new environment, but for how long? More than likely the same problem will be encountered after a short time, and there will be no recourse but to take the same road: the road of least resistance, the road to oblivion. Surely no one will dispute this. It has happened countless times. Why then do we get such remarks thrown at us as "Why don't you quit?" Why not indeed! We are classed as nonentities. Are we also to be classed as fools? Are we being foolish in demanding that our right to equality be considered and that our principles be upheld? Or is it the hospital administrators who are the fools for upholding and propagating such antisocial and un-Christian rules? We should no longer be forced to accept the barbarous conditions which were imposed upon us so long ago.

MUST RELY ON NONPROFESSIONALS

In the modern hospital, the *fact* must be squarely faced that professional nursing and medical care must rely on the nonprofessional worker. The bulk of a hospital's nonprofessional duties is rendered by subsidiary workers. We are not trespassing on the forbidden ground of professionalism when as conscientious men and women we reiterate our demands.

Let modern hospitals realize their shortcomings with regard to their subsidiary workers and stand ready to initiate programs that will better their lot and treat the individual as a personality first and as a worker second. Let them be receptive to constructive criticism of their personnel policies, without regarding such criticism as heresy and without seeking to preserve a status quo that alienates patients and employes and stultifies and retards the hospital.

Punch Card Accounting

lightens the load of paper work

FRANK R. BRADLEY, M.D., and WILLIAM ANDERSON
Respectively, Director and Comptroller, Barnes Hospital, St. Louis

PAYROLL III

THE pay roll master cards are sorted by employe number, account number and hospital, and the department name and number cards of each hospital are merged with the pay roll master cards on hospital and account number.

Time sheets are then prepared for each department, showing department name, hospital, account and suffix number, together with the employe's name, employe number, base period, salary or rate, tax code and pay roll period. The completed time sheets are forwarded to department heads who record the regular time in the upper block of each employe's time section, and overtime in the lower block. The time sheets are then returned to the tabulating department for processing.

The department name cards are sorted from the pay roll master cards on entry field, and then filed by hospital.

The pay roll master cards of each hospital are reproduced into a set of current earnings cards, showing name, employe number, social security number, hospital, account and suffix number, entry, nursing division, marital status, shift and tax code. After the pay period chart code for period ending number has been referred to, this information is gang-punched on the current earning cards.

Current earnings cards are interpreted, and the name, employe number, hospital, account and suffix number, nursing division and tax code are printed. They are then filed by hospital.

As soon as the time sheets are returned to the pay roll department by the department heads, the paymaster totals the regular days, hours and overtime of each employe and also computes gross earnings, placing the computation in the proper column on the time sheet. The gross earnings of all employes for each department are totaled and placed at the end of each department time sheet. After the department gross earnings are totaled, they are posted to the hospital control sheet.

The time sheets are arranged in the same order as the current earnings cards, that is, by hospital and account and suffix number.

Key-punched into the current earnings cards are the following: days, regular hours, overtime hours and gross earnings. Before the key-punching is done, names on each current earnings card must be checked with the name on the time sheets. Cards of employes who did not work this pay period are pulled, and the time sheets and cur-

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This is the sixth article in a series by Dr. Bradley and Mr. Anderson on the machine accounting procedure in use at Barnes Hospital, St. Louis. Successive articles on this procedure will appear in forthcoming issues of this magazine.

SHEET_____ OF_____

BARNES HOSPITAL

PAYROLL REGISTER

DATE_____

NAME	EMPLOYEE NUMBER	BASE PERIOD	DEPT.	SHIFT	NURSING DIVISION	MARITAL STATUS	TAX CODE	GROSS EARNINGS	DEDUCTIONS							NET EARNINGS	PAY PERIOD CHART CODE	CHECK NUMBER	YEAR-TO-DATE	
									FEDERAL TAX	CITY TAX		GROUP HOSP.	GROUP INS.	ROOM & LAUNDRY	UNIFORM	MISC.				GROSS EARNINGS	FEDERAL TAX
J ARMOUR	21	106		2				4440		21			75			615	3729		38035	49240	
DM BROWN	120	106		2				4610		22			75				4513		38036	53280	
M CREWS	205	106		2				4440		21				450			3969		38037	57708	
L GASTON	324	106		2				4860		24							4836		38038	41262	780
F HOLMES	439	106		2				4620		22							4598		38039	39270	
M HOLMES	472	106		2				4440		21							4419		38040	35890	
AM JONES	505	106		4				4440		21		300					4119		38041	37717	
M LASTER	572	106		2				4920		24					550		4346		38042	42830	30
T MITCHELL	689	106		1				4440	240	21							4179		38043	37302	2235
P MOODY	692	106		2				4440		21			75				4344		38044	38065	
R MOSBY	699	106		1				5760	450	28							5282		38045	48840	3950
R POLK	707	106		2				4860		24							4836		38046	40277	15
OE OYLER	751	106		4				8500		42							8458		38047	68557	
L PENN	784	106		2				7164	240	35		200					6689		38048	61118	2490
AL RAY	820	106		2				4440		21							4419		38049	37185	
MH RILEY	836	106		3				4440		21							4419		38050	37648	
H SWAN	962	106		2				6720	165	33			150				6372		38051	56770	1785
A WALLACE	1018	106		2				4610		22			75				4513		38052	37672	
OB WASHINGTON	1027	106		2				4620		22							4598		38053	39270	
J WATLEY	1030	106		4				7164		35		200	150				6779		38054	61789	
NG WATTS	1035	106		2				4440		21							4419		38055	38046	
A WHITE	1050	106		3				4070		20							4050		38056	35441	
LA WRIGHT	1092	106		1				9000	930	44							8026		38057	77531	8295
M CARROLL	133	106		3				6000		29							5971		38058	49435	
L HEBRON	1464	106		3				4440		21			75			500	3844		38059	36079	
M PERKINS	1500	106		3				4440		21							4419		38060	36056	
JM HUMPHRIES	1586	106		2				4440		21			75				4344		38061	32496	
AV BAILEY	1815	106		2				3960		19							3941		38062	31899	
HM OVERTON	1822	106		2				4200		20							4100		38063	34903	
W LIKE	2261	106		3				6840		33			150				6657		38064	84390	

rent earnings cards are forwarded to the verifying operator.

Current earnings cards are filed by hospital for the pay roll register procedure. The time sheets are filed by hospital.

From the void check listing supplied by the pay roll clerk, a void current earnings card is key-punched for each voided check and the employe name, employe number, hospital, account number, suffix, gross earnings, withholding tax, city tax, first net earnings and check number are key-punched. A void deduction card is key-punched for each deduction being voided as follows: name of deduction, employe number, hospital, account number, entry, name of employe and amount. The cards are then forwarded to the tabulating operator for balancing.

From the prepaid check listing supplied by the pay roll clerk, a current earnings card for each prepaid check is key-punched: employe name, employe number, hospital, account number, suffix, gross earnings, withholding tax, city tax, first net earnings, one in entry column, and check number. A deduction card is key-punched for each deduction, indicating name of deduction, employe number, hospital, account number, entry, name of employe and amount. The cards are forwarded to the tabulating operator for balancing.

From the room and laundry listing, new room and laundry cards are key-punched on those employes who are not having the full amount deducted because they did not work the full pay period. After the cards have been key-punched for name of deduction, employe number, hospital, account number, suffix, entry, name of employe and amount, they are forwarded to the tabulating operator for balancing.

The foregoing lists are filed with the time sheets.

PAY ROLL REGISTER

Following tabulation of the void check, current earnings and deduction cards, totals are obtained of gross earnings: withholding tax, city tax, group insurance, group hospital insurance, room and laundry, final net earnings fields. These sums must be checked against the totals on the void listing.

The prepaid check current earnings and deduction cards are tabulated, then key-punched in time sheet procedure. Gross earnings, withholding tax, city tax, group insurance, group hospital insurance, room and laundry, final net earnings fields are totaled and each is checked against the totals on the prepaid check listing.

The room and laundry cards are tabulated, and the totals are checked on the room and laundry listing.

Withholding tax cards are sorted with the current earnings cards on tax code and amount, and merged. The withholding tax, city tax, and total of the two taxes are intersperse gang-punched into the current earnings cards. Cards of this step are sorted on entry code to separate withholding tax cards from current earnings cards. The tax cards are filed.

The current earnings cards are sorted by employe number, account number and hospital, and the pay roll master cards are merged ahead of the current earnings cards on employe number, account number and hospital. These cards are tabulated, obtaining for each employe number, gross earnings, withholding tax, city tax, the total of the two taxes, final net earnings; simultaneously a new current earnings card is summary-punched showing employe number, hospital, account number, suffix, gross earnings, withholding tax, city tax and final net earnings. After final totals of gross earnings, withholding tax, city tax, the total of the two taxes and final net earnings have been obtained, the totals are proved.

The pay roll master cards are sorted from the current earnings cards on entry code, and the pay roll master cards are filed.

The summary-punched current earnings cards are tabulated, and the gross earnings, withholding tax, city tax, and final net earnings totals are checked against the totals obtained. The cards are tabulated a second time to obtain the total of gross earnings of each hospital and are balanced against the control sheet supplied by the paymaster. The old current earnings cards are then destroyed.

Department name cards of each hospital are merged in front of the associated current earnings cards on hospital, account number, and suffix number fields. The hospital title cards are filed in front of each hospital group of cards.

A listing is made of the title cards which are tabulated on account and suffix number, group indicating department name, account and suffix number so that the total number of employes and earnings of each account

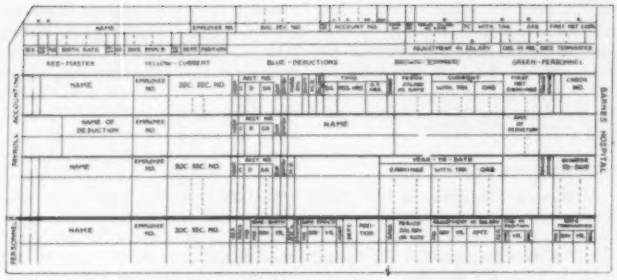
DEPARTMENT 14061
LAUNDRY

TIME AND EARNINGS

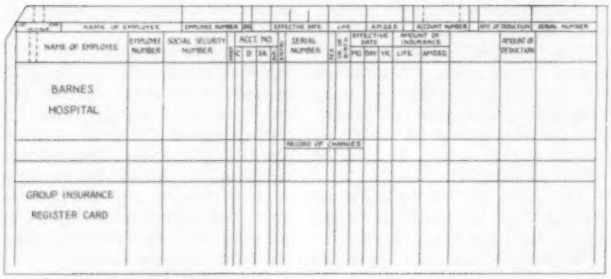
PERIOD ENDING 8 15 50
APPROVED

EMPLOYEE NAME	EMPLOYEE NUMBER	DAYS 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 / 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	REGULAR DA.	REGULAR HOURS	O.T. HOURS	PERIOD SALARY OR RATE		GROSS EARNINGS	WITHHOLD TAX	O.A.B.I.	FIRST NET EARNINGS
J ARMOUR	210					370	2				
DH BROWN	1200					385	2				
H CREWS	2050					370	2				
L GASTON	3240					405	2				
F HOLMES	4390					385	2				
H HOLMES	4720					370	2				
AM JONES	5050					370	4				
M LASTER	5720					410	2				
T MITCHELL	6890					370	1				
P MOODY	6920					370	2				
E MOSBY	6990					480	1				
R POLK	7070					405	2				
DE OYLER	751R					850	04				
L PENN	7840					597	2				
AL RAY	8200					370	2				

PLEASE USE STANDARD SYMBOLS - FULL DAY X HALF DAY / ABSENT O SICK S VACATION V FIRST LINE REGULAR DAY OR HOURS - SECOND LINE OVERTIME HOURS



Above: Sample of the pay roll accounting card.



Above: Group life insurance deduction card.

and suffix number are obtained. A final total of gross earnings and number of employes is obtained. The final total of gross earnings is checked with the control sheet total, and this copy is forwarded to the director of the hospital. The cards are sorted on entry column to select out department name cards of hospital and filed.

The foregoing step is repeated, listing title cards and tabulating the current earnings cards with the control on account number, group indicating account number, and obtaining gross earnings of each account number. The final total is checked with the control sheet. When the report is forwarded to the accounts payable clerk, a check is written and sent to the bank to cover the pay roll checks which will be cashed.

Sufficient check number cards, beginning with the number on the first pay roll check to be issued, for the present pay roll are removed from the file. After the sequence on the check number cards has been checked, the prepaid checks and void current earnings cards are sorted out.

The check number cards are placed in the reading unit of the reproducer, and the unselected current earnings cards are placed in the punching unit. Check numbers are reproduced from the check cards into the current earnings cards. The check number cards are filed in the check number file upon completion of this step.

Group hospitalization deduction cards are merged with group insurance deduction cards on hospital, account and suffix number, and the employe number. These cards are merged with room and laundry deduction cards on hospital, account and suffix number, and employe number.

The deduction cards are match-merged with the current earnings cards on hospital, account and suffix number, and employe number, and all unmatched cards are selected out. These represent employes who did not work during the pay period.

The prepaid and voided current earnings cards are merged with the deduction cards on hospital, account and suffix number and employe number; then these combined cards are merged on hospital, account and suffix number and employe number.

These cards are tabulated, with control on account and suffix number, printing account and suffix number, obtaining the total number of employes, gross earnings, withholding tax, group hospitalization, group life insurance, room and laundry, miscellaneous deduction, and net earnings for each account and suffix number. Cards are then rerun to obtain a final total of these fields for each hospital, and the totals are checked with the control sheet totals. The year-to-date summary cards are merged behind these cards on hospital, account and suffix number, and employe number.

The cards listed in the foregoing paragraph are tabulated for the pay roll register, with control on employe number and intermediate control on account and suffix number; simultaneously a new year-to-date summary card is summary-punched, showing the employe number, hospital, account and suffix number, year-to-date gross earnings, year-to-date withholding tax. Entry and date are gang-punched, and a final total is obtained of gross earnings on each of the deduction fields, net earnings, year-to-date gross earnings, and year-to-date withholding tax for each hospital. These final totals are then checked with the pay roll control sheets.

Cards coded 1, 6, 9 or 7 are selected out, and the rest of the cards are held for future use.

Current earnings and year-to-date summary cards are selected out, and placed in the collator; the first card of each employe number is selected and the unselected cards which represent previous pay roll summary data are removed from the file.

The remainder of the cards are placed in the reading side of the reproducer with the cards previously punched at the time the check register was prepared, in the punching unit, thereby reproducing name into summary cards. Totals are obtained on year-to-date gross earnings and year-to-date withholding tax, comparing results with control sheets.

New year-to-date summary cards of employes are interpreted, printing name, employe number, social security, hospital, account and suffix number, year-to-date gross earnings, and year-to-date withholding tax, and filed for use in the next pay roll.

The previously selected current earnings cards are merged with deduction cards on hospital, account and suffix number, and employe number.

PAY ROLL CHECKS

From cards used in making the pay roll register, a pay roll check is prepared for each employe of the hospital. All prepaid and void check cards are eliminated first. Checks are printed, with the control on employe number, at the same time that a card is summary-punched for each employe, showing check number and amount. As the checks are written, they are compared occasionally as to check number and the name of the check with the pay roll register for verification.

After the last pay roll check has been written, prepaid check cards are tabulated, summary-punching a card for each employe as in the foregoing paragraph. The voided checks are tabulated, and a final total is obtained, which should equal the total of the net earnings field on the pay roll register for all hospitals. A check is written for the amount of withholding tax, room and laundry, group hospitalization, group life insurance, Community Chest, and garnishee deductions from the cards that were key-punched after the total of each type of deduction had been verified.

The check summary cards are tabulated, and the total is balanced against the net earnings field of the pay roll register of all hospitals.

Summary cards are filed by check number, and are placed directly behind summary cards of checks issued prior to the current pay roll that have not cleared the bank. The summary cards will be used in the bank statement reconciliation procedure.

Cards used to write employe pay roll checks are sorted on entry code. Each type of card is separated as to group hospitalization, group life insurance, room and laundry, Community Chest, miscellaneous deduction, and current earnings. Each of these groups of deduction cards is filed by hospital.

BANK STATEMENT RECONCILIATION

A check card is key-punched for each canceled check returned from the bank, showing check number and amount. Cards are totaled, and the total of paid checks is compared with the bank statement. The cards are then sorted on check number.

Summary cards of the pay rolls for the 15th and 31st of the current month are placed behind the previous pay roll check summary cards that were not matched, representing checks not paid by the bank.

Cards which represent paid checks are matched with the pay roll check summary cards on check number and amount, and any unmatched cards which represent outstanding checks are selected out. Outstanding check cards are tabulated and a total is obtained.

Unmatched cards are filed by check number. They will be matched against canceled checks when the next month's bank statement is reconciled. Matched cards are filed in the inactive file for any future checking or reference.

YEARLY W-2 STATEMENT OF INCOME TAXES WITHHELD ON WAGES

With the year-to-date summary cards of the last pay roll of the fiscal year, a total is obtained of the year-to-date gross earnings and withholding tax fields. These totals are compared with the pay roll control sheet, and cards are sorted on employe number. These cards are then matched and merged with address cards on employe number.

The next step is to list on W-2 forms, printing the employe name, marital status, social security number, year-to-date gross earnings, withholding tax on first line, and address on second and third line.

Final totals of year-to-date gross earnings and withholding tax are obtained, and checked with totals on the pay roll control sheet.

To separate address cards from year-to-date summary cards, they are sorted on entry code column. In order to clear the file for the new year, cards of employes who have left the employ of the hospital are discarded.

The final step is to distribute copies of the completed W-2 statements.

The Children Are Remembered

THE Children's Memorial Hospital, Chicago, has been the recipient of significant gifts ever since it was organized in 1882. Mrs. Julia F. Porter founded the hospital in memory of her own young son, Maurice Porter, and named it for him. One of the present 11 buildings bears his name. Five others memorialize someone specified by the donor.

In the early years these donors were few in number. Records of 1891 list only four cash donations but feather beds, barrels of apples, and operating instruments were more frequent gifts. In 1904 there were 25 cash donations. By 1938 they had increased to 301. The hospital still receives gifts other than cash, such as flowers, books and toys, but fortunately the number of cash donations has grown so that indigent patients can receive modern hospital care even at its present high cost. In 1949, more than 2000 persons contributed money to the hospital and clinics.

For many years a generous contributor has arranged for a party on the anniversary of her husband's birthday. No matter where her travels take her, she always remembers to plan with the nursing department to give a party for all the children who are physically able to enjoy it because her husband never had a party when he was a child.

Several board members provide for parties on days their children or grandchildren celebrate their own birthdays. Special favors, ice cream and cake are served on national holidays to children whose diets are not limited.

These parties, which impress the child with the names of George Washington and Abraham Lincoln, and the significant Easter party are not covered by the hospital budget. They are financed by some thoughtful friends.

Memorial gifts toward the general operating expense in the care of sick children have been the custom of many. Formal cards of acknowledgment, on which individual names are inserted, are sent to the donors and members of the bereaved family whom the donor specifies. The only reminder for continuing such gifts has been a folder, "Remembering a Child," which is sent to former contributors. The folder suggests that special occasions, such as anniversaries and birthdays, also may be noted by gifts to help care for a sick child. In 1949, we received 124 memorial gifts amounting to $2146. These do not include gifts of $500 or more for the support of a bed.

The auxiliary board's only solicitation for funds on a wide scale is a mailing of Christmas cards which tell of the hospital's needs. Response to this appeal has been an increasing number of contributions.

THEY MADE HOSPITAL HISTORY

JOHN SHAW BILLINGS

By OTHO F. BALL, M.D.
President, The Modern Hospital Publishing Company, Inc.

John Shaw Billings, M.D.

PERHAPS there is a coming time when all that is now crooked may be made straight, when every doctor shall have an abundance of cases, all of which he can diagnose at once, and cure without delay, while at the same time the welfare of the people shall be so advanced that there shall be no more sickness, and everyone shall die in euthanasia at the age of 100 or thereabouts; but I, for one, am glad to have seen the world as it now is, rather than to have known the millenium only."[1]

John Shaw Billings, writing this out of the fullness of his own remarkable life, was "a man who combined qualities of head and heart such as none of us will see again."[2] The greatest builder of his age, he created a great hospital, a great library and a monumental bibliographic work. All this, because "he selected those things which it was essential to do with unerring instinct and did not waste his time over unessential matters."[3]

His energy unfailing and his industry unceasing, Billings found his only relaxation in a book or in turning to some new task—this, despite his chronic ill health, a relic of the deprivations of his college days when he sold his coat to buy his textbooks, lived in the hospital and tended the dissection rooms, existing on cornmeal mush, milk and eggs, at a cost of 75 cents a week, tutoring through the summer vacations or lecturing for a magic lantern show traveling down the Mississippi. And always when he could, poring over a book. At 8 he had read the Bible through; at 15 taught himself to read Latin, and later learned Greek and German that way.

Born in Indiana in 1839, Billings was graduated from Miami College, Ohio, in 1857 and from the Ohio Medical College in 1860, where he became demonstrator in anatomy. While writing his graduation thesis, his great inspiration and aspiration were born. To obtain the statistical data for his thesis, he searched for six months through the indexes of 1000 volumes in the public and private libraries of Cincinnati, Philadelphia and New York. He noted that 100,000 medical volumes were scattered throughout the world, with no one library in this country having even a fair collection, and nowhere was there an index to guide the student in his bibliographic research. He decided that some day he would remedy this wasteful condition.

Without personal ambitions, his was a vision of service to medicine and to mankind. During the Civil War he served fearlessly, caring for the wounded under fire, transporting the patients, ordering the supplies of the hospital, doing the major operations, and even burying the dead, until he was exhausted.

This was the end of his surgical career. Assigned in 1864 to the surgeon general's office in Washington, he applied himself for 30 years to its endless routine, relieving the pressure of details with study of the microscope and dissection. With the consent of the surgeon general he undertook other projects, set up the Marine Hospital Service and, taking over the small library of the surgeon general, developed first the Army Medical Museum, then the Army Medical Library. When he was made director of the library, his great dream became real. Collecting medical works from all over the world, he built a library that grew from the 1800 volumes of 1865, to more than 300,000 books, journals and pamphlets by 1895, bringing together the greatest collection of medical books in the world.[4]

With the assistance of Dr. Robert Fletcher, he had begun his greatest contribution to medical science, the "Index Catalogue," publishing the first volume in 1880. They also published the monthly "Index Medicus" for current use while the first series of the "Index Catalogue" was being prepared. When in 1895 he left the library on retirement from the army, the first series had been completed. The catalogue proved of tremendous value in America and in Europe; other series followed until only recently, when for various proffered reasons, the great work was stopped midstream, after the letter "M."

Billings regarded this stupendous task as a "labor of love." Because of its inestimable value, it remains a monument to this great man. Few could have contemplated such a herculean task, fewer still could have carried it to success.[5] "He brought to

this work powers which are rarely united in one man and the amount of knowledge of books, medical and nonmedical, which few possess."[2]

Some[3] have thought that his most eminent services to the public were those of planning, constructing and organizing the Johns Hopkins Hospital. His plan called for the highest type of teaching hospital, with physiological and pathological laboratories, outpatient dispensary, and a system of records, historical, clinical and financial. Medical students received their firsthand training at the bedside, not subjecting the patient to amphitheater exhibitions, "lectured over as if he were a curious sort of beetle."[1] The hospital was opened in 1889 and Billings' "Description of the Johns Hopkins Hospital" became a classic in the field of hospital construction.[4]

As though all these enterprises were not enough, Billings served as officer in the National Board of Health and the American Public Health Association, compiled mortality and vitality statistics of the United States census, wrote textbooks on heating, ventilating and sanitation, wrote "A Century of American Medicine," "Medical Libraries in the United States," a "National Medical Dictionary" and a "History of Medicine," in addition to many other notable works. Honors and high offices were showered upon him at home and abroad. Visiting Europe many times, he proved a fascinating speaker; tall and commanding in presence, fluent and with ready wit, he held the rapt attention of his listeners.[2]

His great work at Johns Hopkins completed, Billings in 1889 planned the laboratory of hygiene of the University of Pennsylvania and became its director and professor of hygiene, serving until he was appointed the director of the New York Public Library in 1896. Before he undertook this, his last great work which began when he was 58, Philadelphia gave him a banquet where he received a silver box containing $10,000, the gift of 259 physicians of the United States and Great Britain. An oil painting of Billings was hung in the Army Medical Library. Filled with emotion, the great man said he thanked them from the bottom of his heart, which, however, at that moment was in the region of his larynx.[2] He had ever a modesty and cheerful readiness for self-effacement, yet his erudition was stupendous in medical lore, in history and in literature, his vast reading and retentive memory carrying him into every field of science and trade.[6] However, his vast learning never obtruded and his strong nature, affectionate disposition and kindly ways made him at the same time beloved and trusted by those whom he honored with his friendship.[5]

His was the gigantic task of planning and supervising seven noted edifices, the Barnes Hospital (Soldiers' Home of the District of Columbia), the Army Medical Museum and Library, the Johns Hopkins Hospital, the Laboratory of Hygiene and the William Pepper Laboratory of Clinical Medicine of Philadelphia, the Peter Bent Brigham Hospital of Boston and the New York Public Library. Combining the old Astor, Tilden and Lenox libraries into the New York Public Library, establishing 32 branch libraries, reclassifying its many volumes and building up an efficient personnel of 1000 persons was a gigantic task. For 17 years he served as director. His power for work was always enormous and he possessed an extraordinary ability, self-discipline and a genius for method.[7]

Yet, despite his vigor and tirelessness, he was never well. He never let his many operations affect his work. After the death of his wife in 1912, he began to fail and complained of feeling his years, for he was then 74. His condition grew serious and one day he quietly bade his associates in the library a kindly farewell. A few days later, March 11, 1913, he died.

In Billings' address in London in 1881, he said, quoting from the Talmud, "The day is short and the work is great—the reward is also great and the master presses. It is not incumbent on thee to complete the work, but thou must not therefore cease from it." "Billings of America" lived to see his work completed. As Garrison has said, "Billings will always be remembered in our medical history as one of those who have dared greatly and achieved greatly for the advancement of higher education in this country."

Once when asked how he accomplished so much, Billings replied, "I will let you into the secret. There is nothing difficult if you really begin. Some people contemplate a task until it looms so big it becomes impossible. I just begin and it gets done somehow. There would be no coral islands if the first bug sat down and began to wonder how the job was to be done."[10]

BIBLIOGRAPHY

1. Garrison, F. H.: John Shaw Billings: A Memoir. New York: G. P. Putnam's Sons, 1915.
2. Banquet and Presentation in Honor of John Shaw Billings. Med. News 7:634-41, 1895.
3. Johns Hopkins Historical Club: Special Meeting, May 26, 1913. In Memory of John Shaw Billings. Bull. Johns Hopkins Hosp. 25:244-53, 1914.
4. Lydenberg, Harry M.: John Shaw Billings, Creator of the National Medical Library and Its Catalogue; First Director of the New York Public Library. Chicago, Amer. Library Assn., 1924.
5. Brunton, Sir Lander: Obituary of J. S. Billings. Brit. M. J. 1:642, 1913.
6. Jacobi, A.: Eulogy of John Shaw Billings. Ann. Med. Hist. 1:109-10, 1917-18.
7. Burdett, Henry: A Great Hospital Authority, Colonel John Shaw Billings of the United States Army. Hospital 53:671-73, 1913.
8. In Memoriam: John Shaw Billings. Brit. M. J. 2:685, 1913.
9. Mitchell, S. Weir: Memoir of John Shaw Billings. Science 38:826-32, 1913.
10. Memorial Meeting in Honor of John Shaw Billings. (Richard R. Bowker, one of the speakers.) Library J. 38:334-38, 1913.

ONCE IN A LIFETIME!

IT HAS never happened here," says he when you insist that the rule must be enforced—that fire must be prevented by the strictest application of reasonable precautions, that epidemics must be prevented by the use of foresight and the application of the teachings on this subject which have been so successful, and that crime must be prevented by rules of one kind or another—but "it needs to happen only once" to ruin the reputation of a hospital which may have spent years in constructing a good tradition and a solid place in the hearts of the public.

Preventive administrative medicine, like preventive medicine in general, is a bull market for the hospital investor. Only the immature can be so optimistic as to believe that the standing of the hospital in the community will in itself prevent pain, discomfort, unhappiness, death and tragedy in general among its guests. The science of planning in hospitals is based on a healthy pessimism and fear of the worst. We should profit from experience and protect our charges accordingly.—E. M. BLUESTONE, M.D.

Small Hospital Forum

The Shortcomings of Small Hospitals

The effect of regional hospital planning on the future shape of medical practice, with special reference to hospitals for small communities

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A NUMBER of individuals and agencies prominent in the field of hospital planning have taken the position that general hospitals of less than 50 bed capacity should not be established or perpetuated. The reason given for this attitude is that smaller hospitals are neither as efficient economically nor as adequate from the standpoint of service as are larger institutions.

It is probable that, unit for unit, service of comparable quality is costlier in small than in large hospitals, although some doubts may be expressed on this score, on the basis of our own experience and on the report in *Hospitals* for January 1948. Against a possibly greater cost per patient per day in the hospital of fewer than 50 beds are the time and money saved in travel if a hospital is close to the population group served.

WILL PROBABLY BE EXPANDED

Another factor deserving consideration is that the general hospital of today will probably be expanded about 60 per cent in the future, to provide approximately two beds per thousand population for the care of long-term, chronically ill patients. Thus the 30 bed general hospital will be increased to 50 beds, and the 40 bed hospital will be increased to 65 beds, bringing about a proportionate decrease in the overhead cost: the "ready-to-serve" cost,[1] and in the over-all cost as well.

It is probable also that for *some* types of cases and services, the quality of care is inferior in small institutions. But it is probable that for *many* types of cases and services, the quality of care is equal to that provided in 100 bed hospitals, especially where diagnosis does not present problems.

If hospital care is to be centered in a relatively small number of large institutions, the large hospitals will of necessity be rather distant from many small communities. In these circumstances, at least three factors will operate to shape medical practice along the lines it has taken in England, Australia and elsewhere. Physicians will tend to be divided into two classes: (1) general practitioners in the English sense, for out-of-hospital practice, and (2) in-hospital specialists and consultants. The first factor that will shape medical practice along these lines is the observed tendency of large hospitals to become a community of specialists, with each specialist being limited to a rather narrow field. The physician in the small community 20 or 25 miles distant will be doing a large volume of office and home practice of a general nature. He will not be able to confine himself exclusively to the practice of a single specialty, and he will not fit into or be welcomed on the medical staff of the large hospital.

The second factor is that the time and expense involved in travel from the small community to the large hospital will not make it economically profitable for the physician to care for and follow cases in the hospital.

The third factor is not operating at present, but may become a reality in the not too distant future. There is a definite tendency for medical insurance, voluntary as well as compulsory, to adopt at first a fee-for-service method of payment. This method probably will be rejected because of excessive costs after a few years' trial, and recourse will be toward payment on a capitation or salary basis for home and office practice, and a salary basis for hospital practice, as in England.

There are definite advantages in the division of medical practice and practitioners into the "in-hospital" and "out-of-hospital" groups. The result may be better standards of work in hospitals, and lower cost to patients. It may also direct what we now call general practice into a new type—perhaps best called a "family practice"—with emphasis on psychiatry. Increased attention to preventive medicine may result, although the incentive is not very great nor are the facilities as suitable as under conditions of group practice.

MAY BE HARD ON PATIENT

There are also disadvantages to the predicted division of practice. It seems likely that general practice will become dull, and may deteriorate if it is too far removed from the hospital environment which, with its concentration of patients, is the natural center of clinical teaching. There is also a possibility and danger that each group, the intramural and the extramural, will tend to shove work off onto the other, with the result that many patients will be shuttled between the two, without proper consideration and continuity of care.

The evidence is convincing that group medical practice, properly set up and governed, is the most economical and satisfactory method of providing high quality medical service.

[1] Southmayd and Jordan: A Report on Readiness to Serve. Hosp. 22:37 (August) 1948.

If this statement is accepted, it would then seem unfortunate, at a time when the trend is for more and more care to be given in the home and office (for example, in pediatrics, and in increased diagnostic and treatment service on an ambulatory basis), to break down the one form of group practice that obtains to any extent today, *i.e.* the hospital medical staff.

Rudimentary as this medical staff group is, it is the best that has been developed to date on a large scale and, as has been mentioned, the hospital with its concentration of patients seems to be the natural center for continuous postgraduate education. The hospital would thus seem to be the proper focal point for group practice.

Taking a long view of the trends in medical practice, it would seem ill advised to develop home and office group practice alone, without a hospital as the nucleus for group practice based on home, office and hospital. Also, it seems doubtful that a lay board of governors would assume the necessary degree of interest, responsibility and financial support for a non-bed institution.

Group practice would undoubtedly be better for the future of American medicine than the English scheme cited previously. Group practice provides continuity and variety for the physician, and the close and friendly touch for patient and physician alike. As noted above, it seems doubtful that groups can be organized at this time without a hospital as a nucleus, at least not in communities which do not afford hospital facilities for the physicians. A group of physicians without hospital privileges certainly would not be a well balanced organization.

From the foregoing, it appears that the presence or absence of hospitals in small communities may have a decided effect in shaping the type of medical practice in the future. It seems likely that the retention of small hospitals as nuclei will favor the development of group practice, with well balanced groups providing integrated service in home, office and hospital, and with proper emphasis on preventive medicine and cooperation with allied health and social agencies.

NO SMOKING—But try and stop it!

A MODERN HOSPITAL ROUND TABLE

PERIODICALLY, The MODERN HOSPITAL will invite a group of administrators to sit down in our editorial offices and talk about their problems. A recording of the conversation will be made, and the transcripts will be published here from time to time, after editing to eliminate repetition and irrelevancies. Hospitals of all sizes and types will be represented in these discussions, but the problems selected will be those that seem to emerge in all kinds of hospitals. Readers are invited to write to the editors suggesting topics for discussion at the administrators' round table.

This month, the round table deals with one of today's most important problems, fire safety. Taking part in the discussion, a transcript of which appears here, were Mrs. Edna Nelson, administrator of Women's and Children's Hospital, Chicago (125 beds), Richard Vanderwarker, administrator of Passavant Memorial Hospital, Chicago (225 beds), and Dr. Stephen Manheimer, director of Chicago's Mount Sinai Hospital (285 beds). Everett W. Jones, technical adviser to the editorial staff of The MODERN HOSPITAL, acted as moderator for the group.

MRS. NELSON: The city fire department has been surprised to find that they don't always get the cooperation of hospital administrators in trying to stop smoking in hospitals. Department stores here went to the fire department and got them to issue the ruling that you see posted around in all the stores now. They wanted to do the same thing in the hospitals, and hospital people weren't so enthusiastic about it. I never could understand that.

MR. JONES: But you don't have men patients in your hospital.

MRS. NELSON: Yes, we have men, too, and just today a man saw me pass the door to his room, and I looked on the back of his door and saw the "No Smoking" sign, and the next time I went down the hall, I could see him smoking under the sheet, which is much more dangerous!

MR. JONES: You mean to say that you really do try to keep patients from smoking in your hospital?

MRS. NELSON: We do, because we don't want to be partners to the dangers of smoking. We tell them that it is against the law. We have had a fire captain in to give us a lecture, and he said that it is our job to tell them. We have "No Smoking" signs in each room.

MR. JONES: Have you ever had any fires caused by people smoking in bed?

DR. MANHEIMER: Since the recent hospital fires, we have become very cautious. Shortly after the LaSalle Hotel fire, we had signs made which we hung right opposite each bed saying, "Please do not smoke in bed. It is a great fire hazard!" We were told to do that by the fire department. I hope we will never experience a fire from smoking. I can see where it might start a fire.

MR. JONES: You don't try to enforce that rule, do you?

DR. MANHEIMER: Yes, we try. We don't succeed very well, but we try.

Any time I walk through the corridors and see a man or woman in bed smoking, I stop it. The nurses do the best they can. I believe that a person smoking a cigaret in bed is a fire hazard. He might fall asleep at any time and drop the cigaret!

MR. JONES: But it doesn't seem to me that the hazard in a hospital is as great as it is in a hotel, because patients' doors are usually open, and a fire could hardly get started without being noticed.

MR. VANDERWARKER: To me, trying to stop smoking in a hospital is like trying to enforce the Volstead Act. It can't be done! I think most patients will put their cigarets under cover and make it more hazardous. So many of the patients are in shared rooms that, even if one did fall asleep with a cigaret, another patient would be likely to detect the fire a lot quicker than would be done in a hotel. I think it is rather a stupid thing to try to do.

MR. JONES: I am just wondering what I would do if I were a patient in a hospital and couldn't have my after-lunch and after-dinner cigars and my pipe in between times when I felt like it. I think I would get up and go out to a hospital that would let me smoke! How about the comfort and peace of mind of the patients? Isn't it better to let them do about as they do at home?

DR. MANHEIMER: Yes, I suppose it would be.

MR. VANDERWARKER: Coming back to the fire hazards—I don't think that the patients are as great a hazard as the personnel.

DR. MANHEIMER: I agree. And we must know what is inflammable and try to eliminate inflammable material from the hospital. Now we have heard of all sorts of inflammable drapes and we have heard how textiles can be treated. Several coats of paint left on walls create a serious fire hazard.

MR. JONES: Unless a doctor specifically orders no smoking for his patients, I don't see how you can stop patients from smoking in the hospital and still keep them happy and contented.

DR. MANHEIMER: Well, you just have to close your eyes to it. Once in a while it is brought to my attention, and I have to say something.

MRS. NELSON: For the first few days he is in the hospital I don't believe a patient wants to smoke, and today, with early ambulation, you can get that patient out of bed on the second or third day. That is just when he wants to smoke—when he gets up. Then you can put him in a wheelchair and take him out to a place that is reserved for smokers and let him smoke to his heart's content.

MR. VANDERWARKER: What about employes smoking around in the laundry and the basement? What do you do about that? Do you permit that?

DR. MANHEIMER: We have places in the basement where they can smoke. We don't allow actual smoking on the job. The only exception to that is the gardener, who works outside. Nobody is permitted to smoke while on the job indoors.

MRS. NELSON: You lose so much time if you allow employes to go out and smoke. We checked on one person who went out about 10 times a day, for 10 minutes each time!

DR. MANHEIMER: We don't often wish to have our businessmen trustees tell us how they run their businesses compared to hospitals, but perhaps the fire hazard in business has some connection with hospital fires. Last week I talked to a man who has been on our board of trustees for a long time and has a large plant where smoking is quite a hazard. As a matter of fact, if he did not eliminate smoking his insurance rates would be much higher. He told me he would rather have all of his people, even those in the office, go out to the rest room five or six times a day for a few minutes and have smoking in a restricted smoking area than have them smoke on the job, because the fire hazard would be so much greater.

MR. JONES: Does the executive smoke in his office?

DR. MANHEIMER: He doesn't smoke.

MR. JONES: It's easy to say, "Don't smoke," if you don't smoke yourself, but if you really enjoy smoking and get some comfort and pleasure out of it, you look at the problem quite differently.

MR. VANDERWARKER: I would be interested to know the cause of fires in hospitals—I wonder if smoking isn't a relatively minor problem—if the fire hazard isn't more a problem of poor housekeeping, storage of anesthetic gases, and so on.

MR. JONES: I think the records show fairly conclusively that not many serious fires in hospitals are caused by patients smoking in bed. I had occasion to check up just about a month ago; I checked around with the administrators of eight or nine hospitals and none of them recognized smoking as a major problem. One of the big fire insurance companies said they had practically no claims from hospitals for fires as the result of patients smoking in bed. They recognized, however, that bad housekeeping, accumulation of wastes, oily rags, dirt and inflammable materials around the hospital, and employes smoking and carelessly tossing their cigarets away were real hazards.

MRS. NELSON: Our wastebaskets are always catching on fire from somebody smoking and tossing in a cigaret butt.

DR. MANHEIMER: My recollection is that of the few fires that I have heard of—very minor ones—one was caused by a short circuit and another by spontaneous combustion of oily paint rags.

MR. JONES: That is an important point. Never let oily paint rags accumulate. They are a hazard.

DR. MANHEIMER: But some of the fires start in wastebaskets.

MR. JONES: But not in patients' rooms?

DR. MANHEIMER: No. I think I recall one on a patients' floor, where the wastebasket caught fire. I think it seems to be the opinion of this group here that patients' smoking is really not a serious fire hazard. And yet in Chicago we're supposed to stop it!

MR. JONES: I wonder about signs in patients' rooms saying "No Smoking." I think it's worse to put up such a sign and not enforce it than never to have had it in the first place. We could put up a sign saying, "Smoking in bed is hazardous; we suggest you don't do it," but not make a rule if you're not going to enforce it. What do you think about that?

MR. VANDERWARKER: I think it's very sensible. We could warn people not to do it. But don't tell them they can't unless you're prepared to carry out the rule, and we all know you can't carry it out.

MR. JONES: Have any of you had one of these inspections by the National Board of Underwriters and the American Hospital Association?

DR. MANHEIMER: We have. We asked them to look for all these fire hazards, as we wanted to correct them.

MR. JONES: That's interesting. Did their recommendations include expensive changes?

DR. MANHEIMER: Just a few odds

and ends. They didn't want mattresses stored in basements, for one thing.

MR. JONES: Did they make suggestions you couldn't carry out?

DR. MANHEIMER: Oh, no, we carried them all out. As a matter of fact, one of the best things they recommended, although we had it in mind before, was a planned fire drill, and we are doing that right along. Each time we have a new class of nurses we teach them what to do. We have a man in our organization who was in a volunteer fire brigade somewhere. He is very much interested in fire prevention and has been with fire department personnel quite a bit. He has undertaken to be the leader of our fire prevention work. We have movies which we show, and then we have periodic instructions on how to use fire-fighting equipment, chemical extinguishers. We take a group of nurses out in the yard and start a fire in a can or container and show them how to use this. We have fire department personnel with us to show them how and explain the functions of the extinguishers, and we have photographs.

MR. VANDERWARKER: I'm very much interested. Do you have fire drills for your employes?

DR. MANHEIMER: We have fire drills in the nurses' home and outside the home. We have found that if we do it in the hospital it alarms the patients. One thing that I did not long ago was to have fire rule signs printed on laminated paper covered with plastic. We put these signs at various locations instructing the people what each one should do in case of fire—what the head nurse, the engineer, and the telephone operator should do, and so on down the line. We think it is necessary to remind employes constantly of their fire duties.

MR. VANDERWARKER: That has been one of our problems on a three shift basis. If we could just ring a bell like they do at school, it would be different, but we can't ring any bells.

MR. JONES: What do the inspectors from the board of underwriters say to you about fire drills when they make their report?

DR. MANHEIMER: They just say, "Have people informed and tell them what to do." The main thing that they talked about to us was to get the patients moved to a safe area. Not to try and get them out of the building, but move them to a wing where they would be safe.

MR. JONES: Do you have plans for evacuating patients from the area where a fire is into other, safer areas?

DR. MANHEIMER: I suppose you could pretty near sum up this fire business with the general statement that good housekeeping all over the place is essential. You have to have written instructions on what every person's job is in case of fire, but just having written instructions won't do much good unless you are certain that every employe understands them, and how are you going to know that every employe knows what the instructions are unless you quiz them?

MR. JONES: Do you think it a good idea to make arrangements with your local fire department for periodic inspections and reports?

MRS. NELSON: We do. We are very close. We bake cookies for them at Christmas and Thanksgiving, and they come over and visit with us. We have a very nice arrangement. We invite them to come in and give us a lecture on fire prevention once a year.

MR. JONES: I think it is a real advantage to have an outsider who isn't familiar with everything in your hospital to go through the place regularly on periodic inspections. He will see a lot of things that you folks will never see. That is one of the important things you can do in fire prevention. The two or three recent disastrous hospital fires have made everybody reexamine all the rules we used to have. Fire departments are asking us to do things they wouldn't have asked us to do two years ago. I suppose a hospital would be in a pretty bad spot legally if it had a bad fire and it could be shown that it had neglected to carry out safety recommendations. For example, any hospital now that doesn't carry out all of the recommendations of the new report on safe practices in hospital operating rooms would be in a pretty bad spot if it had an explosion.

MR. VANDERWARKER: Should we take out good floors and change them?

MR. JONES: Not if the floors you have satisfy the N.F.P.A.

MRS. NELSON: What would you do if the inspectors say that electric outlets should be 5 feet from the floor, but one installed by mistake a few inches lower is O.K.?

MR. JONES: Better get that inspector to put it in writing!

In their next discussion, to be published soon, members of the round table group will discuss physical histories.—ED.

• For More Humane Attitudes in Surgeons

IF WE assume that the criticism of modern surgery now appearing in the lay press is true, why has the situation arisen, and what can the surgeon do about it? This was the subject of a presidential address delivered by Harry B. Zimmerman, M.D., at the 56th annual meeting of the Western Surgical Association and reprinted in the May 1949 *Archives of Surgery* as "More Human Attitudes in Surgical Practice."

The author states that the main reasons for these accusations of "not living up to our traditional reputation for altruism and devotion to the service of mankind" are three: overemphasis on technical surgical achievement, the presence of a small minority of dishonest surgeons, and ignorance of nonsurgical therapeutics.

Too many surgeons, the author believes, feel that technical skill is the best indication of surgical proficiency. To these knife-wielding "stunt pilots" the main purpose of an operation is often not to cure the patient, but to enhance their own reputations.

SELECT STUDENTS CAREFULLY

To counteract such conditions, the author urges more careful selection of medical students and a change in the slant of the premedical curriculum from the basic physical sciences to the broader ethical, cultural and social aspects of knowledge. "Philosophy and the humanities are the salt for science."

Specialization should not be accented in the medical school—all the therapies should be equally represented. Graduate training could well borrow the custom of some of the larger cancer centers where the resident serves in all the therapeutic departments and is thus able to consider surgery as but one of many possible procedures. This also serves to minimize the ancient feud between surgeons and physicians.

"Persons who are preparing for medicine and surgery will have to deal with the destinies of human beings and must have humane knowledge. Their knowledge must be liberal, humanistic and man-centered."—JOHN D. THOMPSON, *Montefiore Hospital, New York City.*

About People

Administrators

Dr. Martin Cherkasky, chief of the division of social medicine at Montefiore Hospital, New York City, has been named director of the hospital to succeed **Dr. E. M. Bluestone.** Dr. Bluestone, who has been director since 1928, has been advanced to the rank of consultant to the hospital. Dr. Cherkasky, a graduate of Temple University School of Medicine, has been physician in charge of the family health maintenance demonstration recently inaugurated by Montefiore. He is chairman of the National Health Conference on Treatment and Management of Cardiovascular Diseases.

Dr. Martin Cherkasky

Dr. E. M. Bluestone

Dr. Bluestone began his career in hospital administration as assistant director of Mount Sinai Hospital, New York City, under Dr. S. S. Goldwater, a position he held from 1920 to 1926. From 1926 to 1928, he served as director of the Hadassah Medical Organization for all of Palestine with headquarters at Jerusalem. He is a charter fellow of the American College of Hospital Administrators, life member of the American Hospital Association, in which he has served on various committees, and member of the editorial board of The MODERN HOSPITAL.

Other appointments to the hospital staff include those of **Dr. Samuel W. Friedman,** who was named assistant director; **Dr. Philip A. Lief,** attending anesthesiologist; **Elizabeth B. Torrance, R.N.,** nursing executive, and **Naomi M. Parness,** assistant personnel executive.

A. M. Heyberger has been named assistant administrator of Baroness Erlanger Hospital, Chattanooga, Tenn., where his duties will include supervision of Carver Memorial Hospital in addition to heading the hospital's personnel and public relations departments. Mr. Heyberger has been assistant superintendent of Bradford Hospital, Bradford, Pa., for the last two years.

Carl P. Wright Jr., has been appointed administrator of Woman's Hospital, New York City, to succeed **Dr. Karl Klicka** whose resignation was reported last month. Mr. Wright was formerly director of St. Luke's Home and Hospital, Utica, N.Y.

Delores Pebley has been named administrator of Dunlap Memorial Hospital, Orrville, Ohio. A graduate of Conemaugh Valley Memorial Hospital, Johnstown, Pa., Miss Pebley has been assistant administrator at Harrison-Detwiler Memorial Hospital, Wauseon, Ohio, since 1945.

J. L. Thomas Jr. has been appointed administrator of Guernsey Memorial Hospital, Cambridge, Ohio. He has been serving as clerk of the works since the start of construction of the hospital on June 1 and will continue in the dual capacity of clerk and administrator. The hospital is scheduled for completion next summer. Mr. Thomas served as administrator of Adrian Hospital, Punxsutawney, Pa., for three years, resigning that post last March.

Dr. Henry Farish has resigned as administrator of Mount Sinai Hospital, Philadelphia.

James L. Sexton

James L. Sexton has assumed the duties of assistant administrator of Samuel Merritt Hospital, Oakland, Calif. Following his completion of the course in hospital administration at the University of Chicago in 1942, Mr. Sexton served an administrative internship at Merritt Hospital and Peralta Hospital, also in Oakland. From April 1943 to November 1946 he served in the medical corps, U.S. Army, in England and Berlin, after which he remained in Berlin as a civilian on the headquarters staff of the U.S. military governor.

Dr. Mario Alfredo Fahsen has been appointed executive director, General Hospital of Guatemala. Dr. Fahsen was a member of the class in hospital administration at Columbia University in 1949.

Homer A. Reid, comptroller of Menorah Hospital, Kansas City, Mo., for the last four and a half years, has been appointed assistant director for Fiscal Services, effective January 1. Prior to his association with Menorah Hospital, Mr. Reid was auditor for Presbyterian Hospital, Chicago, and chief accountant for the Illinois Central System hospitals.

Louis P. Funk, formerly business manager of Orange County Hospital, Orange, Calif., is now assistant administrator and business manager of the Santa Cruz County Hospital, Santa Cruz, Calif.

Dr. Gordon M. Meade has been appointed medical director of the Trudeau Sanatorium, Trudeau, N.Y., to succeed **Dr. Edward N. Packard,** who recently resigned to take up private practice in Saranac Lake, N.Y. Dr. Meade had been assistant medical director of the sanatorium since 1946.

Carl I. Flath

Carl I. Flath, administrator of Queen's Hospital, Honolulu, Hawaii, since 1946, resigned recently to return to the mainland. Before going to Honolulu, Mr. Flath had been administrator of Charlotte Memorial Hospital, Charlotte, N.C., for four years.

Dr. Jack R. Ewalt has resigned as director of the Medical Branch Hospitals of the University of Texas and professor of neuropsychiatry of the University Medical Branch at Galveston to become dean of the University of Texas Postgraduate School of Medicine. **Dr. Truman Blocker,** professor of surgery, has been named to succeed him as director of the hospitals.

Robert P. Bryant has been named assistant director of Albany Hospital, Albany, N.Y. Prior to going to Albany as manager of the University Club, Mr. Bryant was assistant resident manager of the University Club in Washington and executive secretary of the Hospital Council of the National Captial Area.

John B. Schroeder has accepted the position of business manager of the Rock Island County Convalescent Home, Rock Island, Ill. Mr. Schroeder received his master's degree in hospital administra-

(*Continued on Page* 166.)

TRENDS IN CHARGES *for short-term care*

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THERE is abundant information on the changing costs of hospital operation from the hospital administrator's point of view. However, data on charges to patients in relation to general economic trends — the consumer's eye view — are relatively scant. Accordingly, a study of patients in a general hospital was undertaken in an effort to identify recent trends and their causes. In this study, charges to patients are related to selected indexes of living costs and of money income. Both are fundamental to an evaluation of ability to bear the economic burden of hospitalized illness.

Such analysis appears essential if all the implications of contemporary advances in medical science are to be understood. Examination of the movement of medical costs together with general economic changes will help not only to explain the recent past, but also to predict future developments. Projection of current trends is required for careful planning for extension of medical services.

The segment of medical care under study here—short-term hospitalization for acute illness — is an important part of the whole. It represents an unpredictable and expensive claim on the family budget. Essential preventive, diagnostic and therapeutic services are concentrated in this phase of the medical care spectrum. The financial relationships are also of administrative importance, since the great bulk of voluntary prepayment plans now cover just this segment of medical service.

Methods and Materials

The study was conducted at Herrick Memorial Hospital in Berkeley, Calif. This is a voluntary, nonprofit general hospital of 225 bed capacity of which 190 are in use, whose patients represent a fair cross-section of the nonindigent persons with hospitalized illness in the East San Francisco Bay Area. (Indigent patients are hospitalized in a county facility, although some free and part-pay beds are maintained by Herrick Hospital.)

The time period surveyed is the decade 1939 to 1948. Data have been gathered for alternate years only. Three conditions requiring hospitalization—broncho-pneumonia, appendicitis and delivery—were selected to illustrate medical, surgical and obstetrical services. After names of patients with these conditions were selected by examination of index cards, the appropriate ledger sheets were located and transcribed. No data could be gathered on bronchopneumonias and appendectomies in 1945 and 1947 because the relevant index cards were not available.

ADJUSTED TO SEMIPRIVATE RATES

All charges to patients were adjusted to semiprivate rates in order to standardize charges at the level which most nearly reflects actual cost to the hospital. Certain cases were excluded as atypical, *i.e.* they terminated fatally or involved serious complications. Only those appendectomy patients between 20 and 50 years of age were studied, on the theory that extremes in age might (in this small sample) bias the length of stay. No age restrictions were used in selecting patients with the remaining two conditions.

In general, the sample consists of a small number of cases selected in a fairly rigorous manner, intended to reflect trends in costs to patients of more or less ordinary, uncomplicated hospitalized illness over a decade's time. Since the samples (and the universes) were small, efforts were made to establish the validity of the trends by testing against mean lengths of stay for all patients and by analysis of variance.

The decade under study, 1939 to 1948, represents the unusual economic period of the second world war—in which consumer purchasing power and employment levels were abnormally high. The postwar trends in real wages, discussed below, have continued in 1949 and early 1950. Data on these years are now under study for further analysis of patients' ability to pay current hospital costs.

The statistical components shown in table 1 form the basis of all reference to hospital cases in the series of five graphs. Data on wages and consumer prices in graphs 1 and 2 were taken from standard sources. The Consumers' Price Index for San Francisco[1] was chosen as the best available indicator of changes in the cost of living. Average (mean) weekly earnings for production workers in five San Francisco Bay Area counties[2] were used as an approximate index of patients' income. Since this indicator includes only employed persons, it is more reliable for the full-employment war years than for the periods before and after World War II. It is recognized, also, that weekly earnings for production workers do not accurately reflect annual incomes for all families. To the extent that illness causes wage loss, and to the extent that patients are affected by general unemployment, these income data are also biased upward.

The major purpose of the study, then, is to relate over-all trends in patients' charges to concurrent changes in ability to pay. Total charges to patients are then analyzed in terms of per diem costs and length of stay, the two significant variables.

Findings

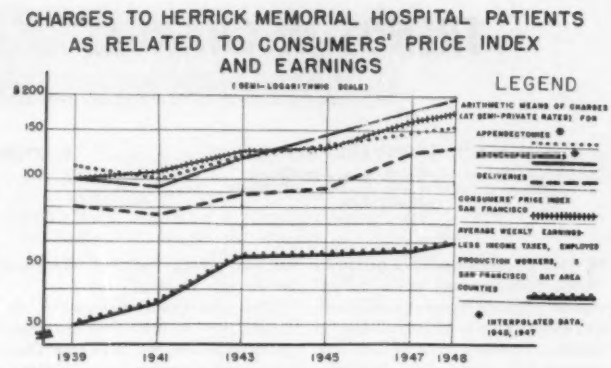
Table 1 on page 78 shows the data on which the graphic analyses are based. Sixty-four appendectomy cases showed a range in median annual adjusted (*i.e.* semiprivate) charges from $97.71 in 1941 to $149.33 in 1948. Mean number of days per case fell from 9.8 in 1941 to 5.2 in 1948. Mean cost per patient per day rose steadily from $10.43 in 1941 to $30.60 in 1948. (The 1939 figures for total and per diem costs are slightly higher than those for 1941, and the length of stay is somewhat less than that for 1941.)

Similar data were revealed by the study of 72 bronchopneumonia patients. Median annual adjusted charges rose during the decade from $75.48 to $164.44 and mean per diem charges, from $10.11 to $23.59. The mean number of days per case fell from 10.2 to 8.6.

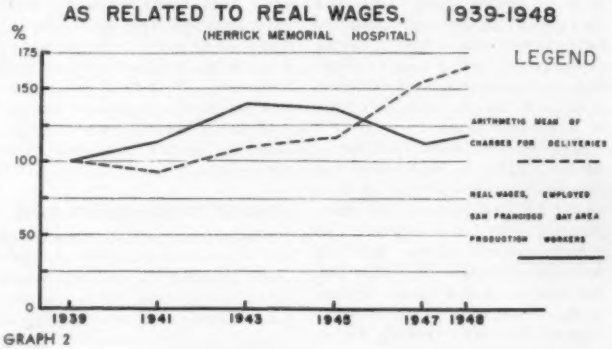
For the 88 normal deliveries, annual median adjusted charge ranged from $71.84 in 1939 to $115.44 in 1947. Mean number of days per case fell from 7.5 in 1941 to 4.9 in 1947. Mean per diem charges rose correspondingly from $9.94 in 1941 to $26.84 in 1948.

Hospital costs as compared with wages and prices. Graph 1, on a semilogarithmic scale, compares the trend in charges per case for the three conditions with the Consumers' Price Index and Average Weekly Earnings. For the decade as a whole, the general upward trend in all factors is striking. Specifically, the price index rose 74 per cent, weekly earnings, 100 per cent, charges for bronchopneumonia, almost 100 per cent, for deliveries, about 67 per cent, and for appendectomies, approximately 37 per cent. Although charges to patients rose for each of the three conditions, there were variations in the timing and extent of the increase.

The over-all 10 year trends are potentially deceptive. Analysis of individual years within the decade reveals a less favorable relationship between consumer incomes and expendi-



GRAPH 1



GRAPH 2

TABLE 1—Hospitalization Charges to Patients at Herrick Memorial Hospital for Selected Conditions in Relation to Sex, Age, Patient-Days, and per Diem Costs, 1939-1948

(Summary of Major Statistical Components of the Study)

Year	Number of		Mean Age, Both Sexes	Mean Patient Days	Crude Charges ($)		Semiprivate Charges ($)		Average Cost per Patient per Day ($)	Per Cent of Total Cost	
	Males	Females			Mean	Median	Mean	Median		Room and Board	Extras
APPENDECTOMIES											
1939	7	9	28.6	9.6	$109.00	$101.46	$112.28	$101.81	$11.60	57.20	42.80
1941	7	6	26.7	9.8	97.51	93.61	100.84	97.71	10.43	60.38	39.62
1943	6	6	30.2	8.7	118.59	119.08	120.91	122.43	14.26	54.28	45.72
1948	7	16	28.9	5.2	149.33	147.91	153.61	149.33	30.60	40.84	59.16
BRONCHOPNEUMONIAS											
1939	7	4	35.6	10.2	101.81	92.71	99.73	91.72	10.11	66.36	33.64
1941	12	6	47.9	9.6	102.56	92.89	93.20	75.48	10.36	60.78	39.22
1943	21	9	43.2	9.6	139.85	103.12	120.00	87.26	12.93	61.31	38.69
1948	7	6	57.6	8.6	225.25	189.86	195.79	164.44	23.59	54.30	45.70
DELIVERIES											
1939		10		7.3	71.49	65.13	80.40	71.84	11.54	54.48	45.52
1941		11		7.5	69.44	68.71	74.83	78.58	9.94	60.50	39.50
1943		12		5.8	83.07	81.08	88.04	95.00	15.63	53.00	47.00
1945		14		5.9	90.88	82.75	93.40	87.30	15.73	61.91	38.09
1947		20		4.9	122.65	111.52	125.08	115.44	26.75	52.07	47.93
1948		21		5.4	135.97	112.00	132.35	111.71	26.84	53.91	46.09

tures in the most recent years. Average Weekly Earnings, an overgenerous indicator of patients' incomes, rose far more between 1939 and 1943 than they did in the years from 1943 to 1948. The Consumers Price Index and hospital charges, however, rose less than wages in the early years of the decade and much more than wages in the period since 1945. The early favorable relationship of income to hospital charges and general consumer prices has been reversed since the end of the war. (This trend has continued in 1949 and 1950. Data on these years are being analyzed for a subsequent paper.)

For purposes of direct graphic comparison, an effort was made to develop one single index of hospital charges and another for patients' ability to pay. To determine which of the three trend lines of charges to patients most nearly reflects the general experience, a comparison was made of data on mean length of stay (inasmuch as such information was available for all patients in the hospital during this period).

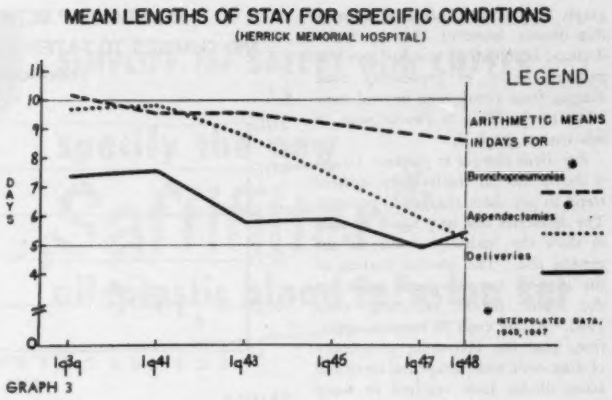
Table 2 shows that the data on length of stay for deliveries closely approximate the general trend. Board and room rates are fixed at any one time, and repeated sampling has shown that there is considerable stability in the ratio of fixed to "extra" charges (see table 1). Therefore, it is possible to use the trend line for delivery charges (graph 1) as an index of the trend in charges to all patients. Interestingly, this line also conforms quite closely to movements of the Consumers' Price Index.

A logical expression of the actual value of wages would relate weekly earnings to the fluctuation in costs of living. Thus the expression:

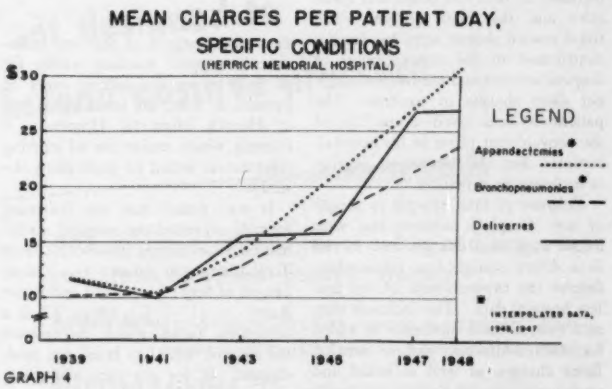
$$\frac{\text{Average Weekly Earnings}}{\text{Consumers' Price Index}} = \text{"Real" Wages}$$

is used to derive an index of the actual value of money wages.

Graph 2 shows this simple relationship. Charges for deliveries are used as an index of all hospital charges and related to real wage levels. It is clear that purchasing power rose more rapidly than did hospital bills from 1939 to 1943. From that peak year, however, real wages have almost steadily declined, while hospital charges have continued to mount. Soon after 1945, the favorable relationship between income and expenditures was reversed, and the relative ability to pay has been consistently falling. Here again, it should be mentioned that for 1947 and 1948 the real wage levels may be too high, inasmuch as they are based on average weekly earnings which ignore the factor of unemployment. This changing relationship between charges to patients and real wages is of profound importance for all future planning of hospital service programs.



GRAPH 3



GRAPH 4

Trend in length of hospital stay. As shown in graph 3, the mean length of stay for all three conditions decreased significantly during the decade. The greatest reduction in length of stay occurred in appendectomies, with deliveries second — reflecting, among other factors, the advent of early postoperative ambulation and the use of newer drugs for the control of infection. The small decrease in length of stay for bronchopneumonias undoubtedly accounts for the virtual doubling of total charges for the condition in

TABLE 2—Mean Length of Stay in Days

Year	All Patients, All Conditions	Deliveries (Sample)	Broncho-Pneumonias (Sample)	Appendectomies (Sample)
1939	7.9	7.3	10.2	9.6
1941	7.6	7.5	9.6	9.8
1943	6.6	5.8	9.6	8.7
1945	6.6	5.9	....*	....*
1947	5.3	4.9	....*	....*
1948	5.5	5.4	8.6	5.2

*Data not available.

graph 1. For the other conditions in this decade, however, the significant decrease in length of stay has been the primary factor in preventing total charges from rising even beyond their 1948 levels. This is clearly seen in relation to graph 4.

Per diem charges to patients. Graph 4 shows the extremely sharp upward trend in per diem charges to patients. The deliveries line may again be used to show the "stairway" nature of the general rise. The greatest portion of the over-all rise has been, again, in the recent period, occurring since 1945. Rising costs of hospital operation, plus the increasing complexity of diagnostic and therapeutic service in acute illness, have resulted in sharp increases in both the board and room rates and the extra charges. The trend toward shorter stays has further contributed to the concentration of hospital services and the resultant high per diem charges to patients. The patient has been saved several days of the convalescent phase of his hospitalization. But the remaining portion is increasingly expensive.

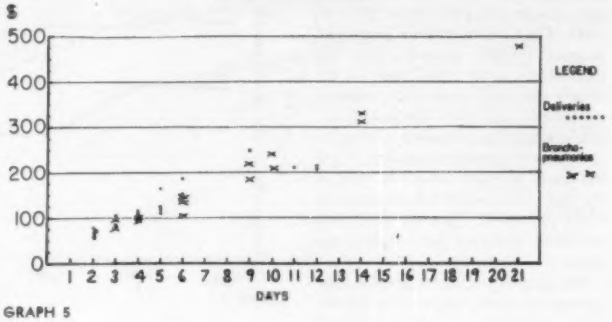
Relation of total charges to length of stay. Graph 5 indicates that with longer stays total charges tend to rise in a direct, straight-line relationship, despite the expensiveness of the first few hospital days. This indicates that, as a rule, a fixed increment is added for each additional day of service. Extra charges, as well as board and room rates, accumulate quite uniformly as the stay lengthens. Graph 5 shows length of stay to be the greatest single factor in total charges to the patient. Accordingly, any satisfactory medico-technical means of shortening hospital stays is of primary economic importance to the patient or his insurer.

Possible New Research Tool

As an outgrowth of work with the statistical data of this study, it seemed possible that the mean charges to any particular group of patients might be derived from these components without tracing down and totaling the individual charges for each patient. Because the traditional method for arriving at the mean presupposes an indexing system with complete and accurate identifying information, and requires the frequently laborious and difficult process of locating hospital ledger sheets, an alternate method seems most desirable. Another consideration in favor of a "formula" approach to average patients' charges is

RELATIONSHIP BETWEEN LENGTH OF STAY AND CHARGES TO PATIENTS, SPECIFIC CONDITIONS, 1948

(HERRICK MEMORIAL HOSPITAL)



GRAPH 5

that mean lengths of stay are sometimes computed routinely either for all patients or for specific types of patients or both, the latter being true at Herrick Memorial Hospital. A formula which makes use of existing information would be particularly desirable.

It was found that the following formula expressed the essential mathematical relationships involved: (Mean Total Charges to Patients) = (Mean Length of Stay) × (Board and Room Rate) × (1 + C) where "C" is a correction factor which incorporates the ratio of "extra" to board and room charges. If, for any particular group of patients, the board and room charges were found to equal 60 per cent of the total charges and "extras" equal 40 per cent (as is frequently the case), "C" equals 40/60 or .667. If several board and room rates are involved, a weighted average board and room rate must be used. Where the mean length of stay is easily obtainable and the board and room rate is known, it is necessary only to obtain the ratio of fixed to extra charges from a sample large enough to ensure statistical reliability. Frequently this is a much smaller sample than that from which the mean length of stay is usually computed, which is often the universe of cases.

The validity of this equation was tested by the known material from three samples of the study. Table 3 shows the accuracy of the results.

It is becoming increasingly important to obtain accurate information on the trends in and levels of charges to patients. Hospital administrators, insurers of many sorts, and governmental agencies need this information to operate intelligently. Wherever the mean length of stay for any particular group of patients is routinely computed or is computable, an appropriate number of ledger sheets can be examined to determine the ratio of "extras" charges to board and room charges. Then the formula can be applied. This should prove in many instances a quicker, easier process than the traditional method of computing mean charges. If so, it may stimulate research and more enlightened operation.

Discussion

The limitations of the data in these small and highly selected samples are clearly recognized. The inadequacies of the Consumers' Price Index as a true indicator of living costs and of the Average Weekly Earnings as a measure of annual family incomes are also understood. Nevertheless, the general trends seem clear. Charges to patients for hospital services in acute illness are steadily rising, and (since

(*Continued on Page* 126.)

TABLE 3—Actual and Computed Mean Charges

	Actual Mean Charges	*Computed Mean Charges*
Deliveries, 1939	$ 80.40	$ 80.39
Bronchopneumonias, 1939	99.73	99.71
Appendectomies, 1948	153.61	153.66

The Over-All Problem in Hospital Finance

J. HAMILTON CHESTON
President
Philadelphia Saving Fund Society
Chairman
Hospital Council of Philadelphia

HOSPITALS are financed by the earnings and savings of the people in several ways: (a) as individual patients who pay the regular charges, in whole or in part; (b) as members of Blue Cross plans or other insurance programs, which contract for payments to hospitals on behalf of the subscribers; (c) as taxpayers who support government hospitals or provide the money for governmental payments to private hospitals, and (d) as voluntary contributors, individually or in groups, to nonprofit voluntary hospitals.

PROPER BALANCE NEEDED

The problem confronting each community is to achieve a proper balance among these methods of financing, so that adequate care will be provided to everyone who requires service, and so that all hospitals necessary to the community will be able to maintain high professional standards.

This over-all financing must include both the operating expenditures for salaries and supplies, and the capital expenditures for replacement and expansion. Although nearly all new plant and equipment in voluntary hospitals has been provided by philanthropy, there is no reason why a continuance of this practice should be relied upon. In fact, there are strong arguments in favor of a pay-as-you-go program for some capital replacement and expansion, through individual patient's fees, as well as payments from contracting agencies such as Blue Cross plans and governmental units.

Each group of the public should be called upon to meet its fair share of all hospital expenditures incurred on its behalf, but the yardstick for the measurement of the charges in the several categories will necessarily vary in different hospital areas.

FROM INDIVIDUAL PATIENTS

In many voluntary hospitals, most of the income is received from individual noncontract patients who pay on a retail basis in accordance with the established charges of the institution. Usually these charges are equal to the costs of the services, and are above costs in private and semiprivate accommodations.

However, a number of individual patients do not pay their bills in full, or even defray the costs of the services they receive. In the Philadelphia area, approximately one-fourth of all patients are listed as part-pay or free. The ratio is nearly 50 per cent for the group not covered by Blue Cross or insurance plans. Losses on part-pay and free individual patients are the pressing financial problem for the majority of the voluntary hospitals throughout the country.

The practice of including in the charges to full-pay patients a margin toward the costs for free and part-free cases is becoming increasingly less effective, both as hospital costs increase and as more and more of the people able to pay hospital bills in full from their private resources are joining group prepayment plans. This policy, which amounts to compulsory charity, has been neither popular with patients nor adequate from the point of view of hospital finance.

The difficulty can be partially overcome by improved procedures in the determination of the ability to pay on the part of patients requesting free or part-pay service. Some of these patients will pay in full, if payments are required in advance or if installment procedures are arranged to commence after discharge.

A permanent solution to the problem of free and part-free service appears to lie in two other procedures: the first is a much wider and more effective cooperation with prepayment organizations to enroll the low-income group for Blue Cross or insurance protection; the second is to work for adequate reimbursement by governmental agencies for service to the indigent and unemployed population. Discussion of both of these methods follows.

BLUE CROSS PAYMENTS

Group prepayment plans of various types are providing an increasing proportion of hospital revenue. For some institutions, the percentage exceeds 50 per cent of a hospital's total current income.

Commercial policies typically provide cash allowances toward the policyholders' bills without any contractual relation between the insurance company and the hospital. In such cases the hospital's problem is to obtain payment of the bill from the policyholder who, in turn, is reimbursed, at least partially, by the carrier. In contrast, the usual Blue Cross protection is a service contract under which member hospitals agree to provide certain benefits to the subscriber in exchange for a stated schedule of payments from the Blue Cross.

The primary problem inherent in Blue Cross payments to hospitals for contract benefits is to reimburse the institutions "enough," in total, to enable them to provide a high quality of service to subscribers. But how much is "enough"? It has been thought by some hospital managements that the institution is amply repaid if it

Condensed from a paper presented at the American Hospital Association convention, 1950.

receives more from a Blue Cross plan than the subscribers would have paid from their own resources. However, it must be obvious that a hospital should receive the full costs of the services which it provides to subscribers, including an adequate allowance for depreciation of plant and equipment.

It is well known that hospitals in a given community incur different costs and do not charge comparable rates for their services. The question is often asked whether it is practical for hospitals to be reimbursed at different rates for the care they furnish Blue Cross subscribers. Such a policy is, of course, contrary to the one-price theory of competitive enterprise, but has been justified by the statement that hospitals are not economic competitors, and that each institution is necessary for services to the general community, including the Blue Cross subscribers. One of several objections to paying hospitals in accordance with their costs is that such a plan tends to reward inefficiency in management.

FEES VARY WIDELY

Some efforts have been made to have Blue Cross pay the equivalent of each member hospital's regular charges for individual patients. In the Philadelphia area, hospital fees vary widely, with some institutions charging four times as much as others for substantially the same special services. Moreover, the hospitals imposing the higher charges are not always the institutions which give the greater volume of free inpatient service or incur the higher costs.

Each hospital's fee schedule is ordinarily arrived at in an amount sufficient to balance its total budget, with the expectation that a certain proportion of individual patients will be unable to pay their bills in full. Payment on a "billings basis," in essence, is a form of "deficit financing." From a practical standpoint, regular charges should be considered only as a ceiling factor in reimbursement by a contracting agency on behalf of a large group of patients. If a Blue Cross plan were to guarantee to pay regular charges it would rightly expect the charges to be reasonably uniform in amount. This would entitle Blue Cross to exert considerable influence in hospital management.

Some Blue Cross plans have cut the Gordian knot of varying hospital costs and charges by reducing contract benefits to the subscribers. They have changed some of the benefits, particularly for board and room, from a "service" to a "cash" basis. This procedure has a certain equity for subscribers, particularly if the unpredictable special items (x-ray, laboratory, anesthesia, and so on) are furnished as unlimited service benefits. But the hospital still must be responsible for the collection of the balance. A limited amount of "co-insurance" is desirable in prepaid health service to avoid malingering. But the uninsured portion of the patient's hospital bill should not be so large as to discourage low income workers from joining a plan. Otherwise, the trend will be to enroll as Blue Cross subscribers those persons who need the protection least, without the hospitals' obtaining the benefits of upgrading individuals who could otherwise have received free or part-pay service.

From the public point of view, it would appear most equitable that hospitals should receive equal, but adequate, reimbursement for equal service benefits. Supplementary allowances might then be made to hospitals with more comprehensive facilities, and for individual cases which impose an unusual burden upon a contracting institution. This policy would enable the low cost institutions to develop even higher standards of care. It would also be an incentive for the high cost institutions to seek more effective ways to maintain their standards—through internal savings, or possibly by merger or consolidation with other hospitals.

It should be remembered that a hospital bill is, on the average, only 50 per cent of the total cost of a hospitalized illness. The doctor's bill, and often that for private nursing, must also be paid. Employer contributions for medical and hospital protection are desirable and necessary if voluntary prepayment is to equal the claims made by advocates of national health insurance.

GOVERNMENT PAYMENTS

Health service is a community concern. Public policy and the general welfare require that medical and hospital care be provided to everyone, regardless of whether he is able to pay the full costs with his own money. The question is: Shall the various governmental bodies provide the needed care in their own institutions or, as an alternative, make reasonable contributions to private institutions which serve free and part-pay cases?

There is a large volume of new hospital construction proceeding under government auspices. Most of this expansion is desirable, particularly in the field of mental health, which has long since been preempted by the various states. Greater emphasis is now being placed upon psychiatric treatment leading to improvement and cure, rather than custodial service leading to deterioration and death. But there is also much construction by federal and local governments for medical and surgical services for the veterans and indigent members of the public. There will be pressure to increase these facilities and make them available to the entire population, if care in the voluntary hospitals becomes too expensive for the average person.

Some governmental units contribute to voluntary hospitals through block grants or contributions to operating deficits. Others reimburse hospitals on a per diem or per case basis for service to patients for which the political unit accepts responsibility.

APPROPRIATED $14,260,000

The commonwealth of Pennsylvania has subsidized voluntary hospitals for more than 70 years. There is only one municipally owned general hospital in the state (located in Philadelphia) and there are 10 state owned and operated general hospitals established in various coal mining regions. Otherwise, all free service for medical and surgical cases requiring hospitalization is provided in voluntary institutions. The state's biennial appropriation in 1949 was $14,260,000 to 174 nonprofit nonsectarian hospitals. This state aid covers about one-half the cost of all free inpatient service in the voluntary hospitals. In the Philadelphia area, the ratio is but about one-third. It includes no allowance for costs of outpatient care.

The main disadvantage of the block grant basis of government aid to voluntary hospitals is the lack of flexibility. Free patients do not distribute themselves according to the amount of each hospital's subsidy or the available community support from other sources. It has seemed impossible for proper adjustments to be made when a hospital's free service is greatly in excess of its budgeted estimate. Moreover, there is created in the mind of the general public an exaggerated idea of the adequacy of the funds which a local hospital receives toward the costs of free care. (*Cont. on Page* 86.)

A contrasting method of payment (being gradually introduced) is governmental reimbursement for services to specific patients who have been formally accepted as the responsibility of the local, state or federal agency, such as the city department of welfare, state department of public assistance, or federal children's bureau. Should each hospital be paid a uniform, and presumably reasonable, amount? Or should it receive its average costs or regular retail charges for service? Certainly there is much to be said for varying payments among communities within a state, but differences based on costs within a community pose a complex problem, and one difficult of solution.

As a general principle, a government should reimburse a voluntary hospital in full for service which otherwise the governmental hospital should have performed. Such reimbursement would make possible a reduction in the scale of rates now charged for private and semiprivate accommodations. These charges in many institutions are burdensome and economically too high, and cannot always be justified by the service rendered. Adequate payment would also permit lower subscription rates for prepayment plans with an increasing number of members among the low income groups.

PHILANTHROPY

There are two main kinds of philanthropic support for hospitals: endowment income and voluntary contributions. This revenue scarcely amounts to 2 per cent of the costs of all voluntary hospitals. Most hospitals have no endowment funds. Only a very few hospitals receive as much as 10 per cent of their revenue from endowment income, and most of them are located on the Atlantic Seaboard. Individual contributions have not decreased in recent years, but they are a constantly shrinking percentage of hospital income.

It seems most unlikely that philanthropy will become an increasingly important factor in the revenue of voluntary hospitals as a group. Voluntary contributions are not a stable source of income. They are hardest to obtain when the hospital's need is the greatest, namely, during periods of unemployment. The conditions which make it hard for unemployed workers to pay their hospital bills also make it difficult for employers and others to make substantial contributions. As to small contributions for hospital support, there is a tendency for many individuals to feel they have done their part when they have taken themselves from the "free list" by joining a prepayment plan, or because they have given to the Community Chest, even though the gift represents but a small fraction of the cost of a hospital case.

Community Chest support of inpatient hospital care was less than $15,000,000 in 1949 throughout the entire country. New York, Boston and Philadelphia are among the few cities where the total annual contributions to hospitals from Community Chests or federations is in excess of $1,500,000. Even in these cities the total group contributions are less than 6 per cent of the total costs of the local voluntary hospitals.

There are two theories of Community Chest support for participating hospitals. One is that it represents a partial contribution toward the operating deficit; the other takes the form of the purchase of service for approved free and part-free cases. The practical problem becomes that of deciding "how much" of the hospital deficit is to be assumed by the Chest, or how many "days" or units of service are to be purchased from the joint contributions. Unfortunately, the total payments to hospitals are, and perhaps must be, influenced by the result of the annual drive for funds. The Community Chest can guarantee neither to meet all deficits nor to purchase a stated number of units of care at an agreed price. Voluntary contributions must be considered as a supplementary form of revenue for voluntary hospitals, rather than a major source of financing. Even if all costs of service to patients were financed by other sources, there would still be an important rôle for philanthropy in the support of professional education and research.

CONTROL OF COSTS

Hospital trustees and administrators should recognize a special responsibility to provide the best possible service at the lowest possible cost. Methods of economy to be continually studied include all the standard practices available to private enterprise, such as the selection, training and supervision of qualified employes, and the effective purchase and use of materials and supplies. But hospitals have much greater opportunities to achieve the greatest good for the greatest number, *viz.* through obtaining full cooperation of the attending medical staff and by coordinating their construction programs and services with those of other institutions. I cannot stress too strongly the importance of careful exploration of this field of opportunity.

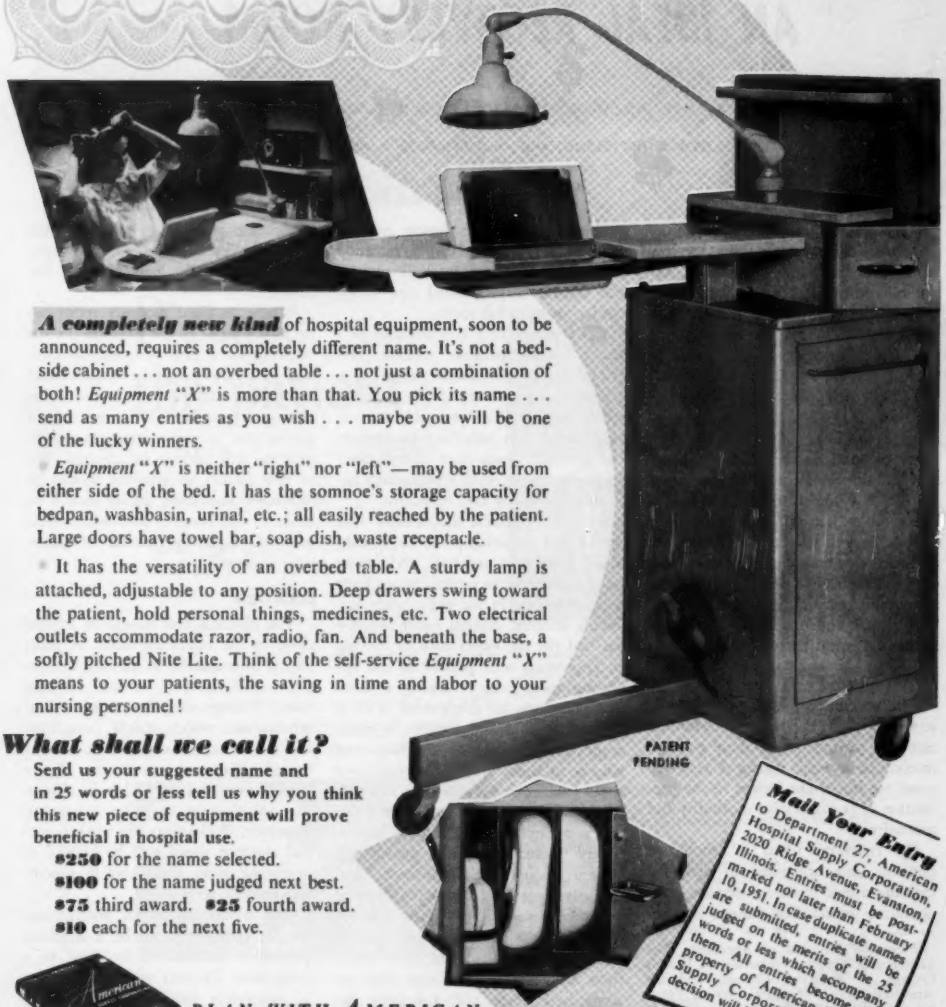
The essential service in a hospital is the medical care performed and supervised by physicians. All other activities are subsidiary to the work of the doctors. It is the physician who determines whether and when a patient is in need of care in a hospital, and when he will be discharged. Likewise, it is the physician who decides which and how many diagnostic and treatment services are needed by a patient. In this way the doctor directly influences both the income and expense of the hospital. Physicians are not always fully aware of the financial effect of their professional decisions. Much improvement, both financial and otherwise, can be accomplished by greater attention to this aspect of hospital management.

CAN COORDINATE FACILITIES

Some hospitals are not large enough to achieve effective use of special diagnostic and treatment equipment. Bed occupancy in hospitals ranges from 50 to 90 per cent of capacity. But it is not uncommon to find expensive scientific apparatus used less than two or three hours out of 24. Substantial savings to the community could be achieved through joint utilization of specialized facilities and personnel. In some cases a small hospital can serve the community best as the special department of a large institution, e.g. maternity or pediatrics. In other cases, the public interest would be best served if complete mergers of institutions were accomplished. Such coordination or merger is often strongly resisted by members of governing boards or attending staffs of the various hospitals. But the time has undeniably come when the community should insist on such action as may be in the best interest of the patient and those who support the hospitals financially.

One of the most effective ways to utilize hospital personnel and facilities is to increase the diagnostic and treatment services for private outpatients. Such a practice is a convenience to the referring doctor and to the patient, and a source of income to the hospital.

$500.00 in Cash Awards for a NAME!



A completely new kind of hospital equipment, soon to be announced, requires a completely different name. It's not a bedside cabinet . . . not an overbed table . . . not just a combination of both! *Equipment "X"* is more than that. You pick its name . . . send as many entries as you wish . . . maybe you will be one of the lucky winners.

Equipment "X" is neither "right" nor "left"—may be used from either side of the bed. It has the somnoe's storage capacity for bedpan, washbasin, urinal, etc.; all easily reached by the patient. Large doors have towel bar, soap dish, waste receptacle.

It has the versatility of an overbed table. A sturdy lamp is attached, adjustable to any position. Deep drawers swing toward the patient, hold personal things, medicines, etc. Two electrical outlets accommodate razor, radio, fan. And beneath the base, a softly pitched Nite Lite. Think of the self-service *Equipment "X"* means to your patients, the saving in time and labor to your nursing personnel!

PATENT PENDING

What shall we call it?

Send us your suggested name and in 25 words or less tell us why you think this new piece of equipment will prove beneficial in hospital use.

$250 for the name selected.
$100 for the name judged next best.
$75 third award. **$25** fourth award.
$10 each for the next five.

Mail Your Entry to Department 27, American Hospital Supply Corporation, 2020 Ridge Avenue, Evanston, Illinois. Entries must be postmarked not later than February 10, 1951. In case duplicate names are submitted, entries will be judged on the merits of the 25 words or less which accompany them. All entries become the property of American Hospital Supply Corporation. Judges' decision will be final.

PLAN WITH AMERICAN
. . . the first name in hospital supplies

AMERICAN HOSPITAL SUPPLY CORPORATION

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Conducted by Robert F. Brown, M.D.

The doctors plan

AN IDEAL RECOVERY ROOM

MAX S. SADOVE, M.D., HENRY E. KRETCHMER, M.D., GORDON M. WYANT, M.D.

LLOYD A. GITTELSON, M.D., and CHARLES B. PUESTOW, M.D.*

THE desirability of adding recovery room services to the services which a hospital offers a patient cannot be contested seriously. All institutions caring for surgical patients should make every attempt to keep pace with the progress which has been made in caring for the patient in the immediate postoperative period. With the increased use of physical aids, oxygen therapy, intravenous fluids, various types of suction, and so forth, there is a definite need for specialized care. In the not too distant future it is conceivable that all surgical patients will be segregated in the immediate postoperative period so that they may receive the benefit of a concentration of equipment and skilled personnel, which will enhance a favorable and rapid postoperative recovery.

PREVENTS MORBIDITY

The continuous, highly skilled observation and the minute-to-minute care and treatment that these patients receive in a well managed recovery room are important factors in the prevention of postoperative morbidity and mortality.

By recovery room is meant a physical unit organized to give the maximum care in the immediate postoperative period. The patient is taken to this unit following surgery, and he remains there until he can be returned to his room, where he will require only routine surgical ward care which can be given in his room.

The recovery unit is established primarily for the patients' welfare. The immediate postoperative period is a dangerous one which, if poorly managed, increases the patients' stay in the hospital, increases their discomfort, and generally leads to a stormy postoperative course, with a potentially increased morbidity and mortality.

It is our clinical impression that the highest incidence of shock, thrombosis, atelectasis, emboli and many other postoperative complications have their inception in the early hours following surgery. Almost every surgeon has had the sad experience of leaving an apparently well patient in the operating room and returning a short time later to be confronted with a patient who has hypotension, hypoxia, cyanosis, an obstructed airway and who is in shock. All these conditions could have been prevented or instantly combated had the patient been cared for in a physical unit such as the recovery room. This unit guards the patient during the immediate postoperative period from catastrophe when vomiting and aspiration, bleeding, chest complications and the like occur. In many instances these conditions are forestalled because they are recognized early and measures are taken to prevent or control their effects.

Proper management of the recovery room requires a different technic from the management of a ward. Many factors are peculiar to the operation of a recovery room. These considerations will be enumerated and discussed.

Where an ideal recovery room can be established, as for example in the building of a new hospital or addition of a new wing, the requirements listed here should be adhered to as closely as possible. It is realized, of course, that in many instances a compromise will have to be effected. But as few factors as possible should be sacrificed, and every effort should be made to add features later which were omitted originally because of necessity or expediency.

LOCATION

The physical unit should be located close to the operating suite. A short trip is thus assured in moving the patient from surgery to the recovery room. Transporting the patient to another floor, which would necessitate the use of an elevator, is a distinct hazard. This movement may be a critical one, and the delay in obtaining an elevator may be dangerous. However, if elevators are used, a special elevator signal will be helpful to operating room attendants in procuring prompt service.

The movement of an anesthetized patient frequently can be a shocking procedure and should be held to a minimum. Patients whose circulation is completely stabilized and who are in good condition can be moved from the operating room table to a cart and then to his recovery bed. However, those patients who have had extensive surgery or radical blood loss,

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*Chief, Surgical Service, Veterans Administration Hospital, Hines, Ill.

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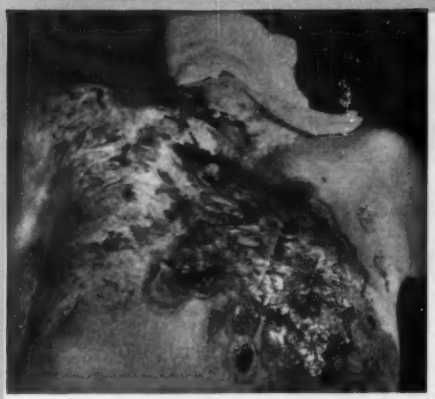
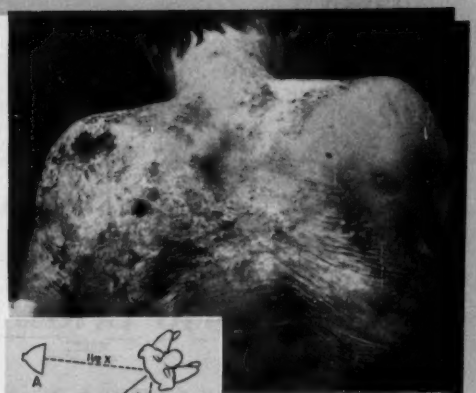
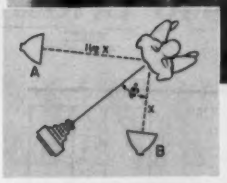




ABOVE: *Blastomycosis, with heavy skin involvement.*
UPPER RIGHT: *Control of infection after treatment.*



Two Kodak Vari-Beam Standlights are arranged as indicated at left. Light A is at camera level; light B is 24" higher than the camera.

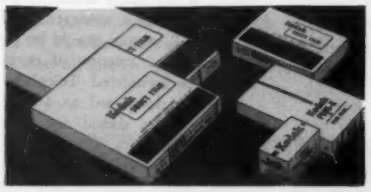
Picture the patient

. . . from initial diagnosis to final discharge

Make photography *routine*. That's the procedure being established in more and more hospitals and clinics . . . by many physicians. Photograph each patient when first seen . . . photograph all phases of the case, in black and white or full color, at designated intervals until dismissal.

Thus, documentation is complete . . . with adequate material available in all significant cases for records, instruction, publication.

BLASTOMYCES DERMATITIDIS: A—*Budding cells in pus. (Photomicrograph.)* B—*Giant colony in Sabouraud's agar.* C—*Growth of test-tube cultures on two different media at room and body temperatures.*



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Kodak products for the medical profession include:

X-ray films, screens, and chemicals; electrocardiographic papers and film; cameras and projectors—still- and motion-picture; enlargers and printers; photographic film—full-color and black-and-white (including infrared); photographic papers; photographic processing chemicals; microfilming equipment and microfilm.

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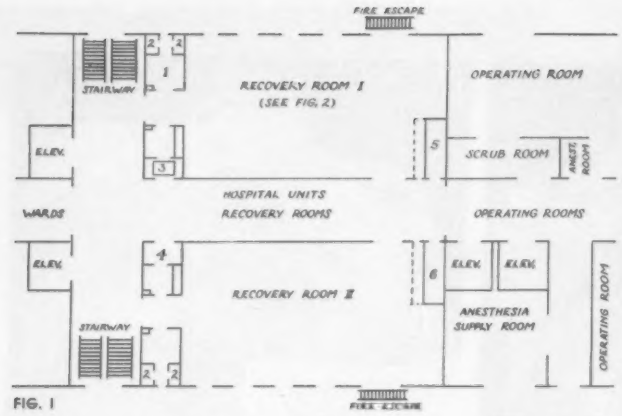

FIG. I

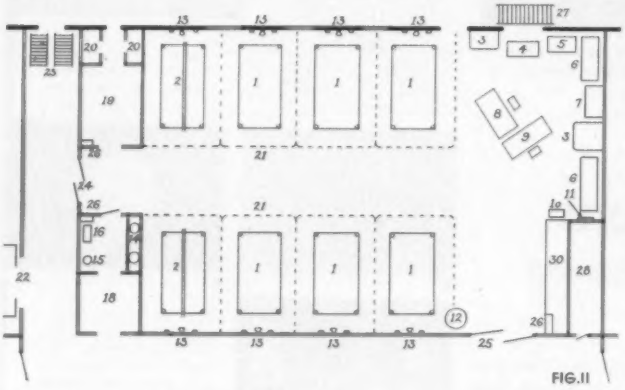

FIG. II

KEY TO DRAWINGS

I. Floor Plan of Recovery-Room Unit and Its Relation to Adjoining Hospital Sections

1. Utility room
2. W.C.
3. Dumb-waiter to central supply
4. Sterilizers and ice storage
5. Oxygen manifold
6. Suction manifold

II. Floor Plan of One Recovery Room With Detailed Equipment

1. Beds
2. Orthopedic beds
3. Sink
4. Mobile dressing cart
5. Small sterilizer
6. Tray
7. Cupboard for drugs and narcotics
8. Table and chair for nurse
9. Table and chair for physician
10. Refrigerator
11. Oxygen gauge for manifold
12. Mobile surgical lamp
13. Wall oxygen and suction
14. Dirty laundry and soiled linen chutes
15. Mobile oxygen tank
16. Mobile suction machine
17. Sterilizers and ice storage
18. Dumb-waiter to central supply
19. Utility room
20. W.C.
21. Rails and curtains for partitioning of unit
22. Elevators
23. Exit stairs
24. Exit door
25. Entrance door
26. Fire fighting equipment
27. Fire escape
28. Oxygen manifold
29. Suction manifold
30. Linen cupboard and store

III. Bed Fixtures

1. Lamp on movable bracket
2. Wall suction with manometer
3. Wall oxygen with manometer
4. Electric bell
5. Folding wall table
6. Power outlet
7. Power outlet (x-ray)
8. Socket for I.V. stand
9. Chart holder

who are in a preshock state, or have marginal circulatory reserve should be moved directly into recovery beds from the operating room table.

Where possible, the recovery room area should be considered closed to hospital traffic and should be located near the elevators. It should be so situated as to receive a northern exposure, so that there is good light without the room's being exposed to the direct rays of the sun.

CONSTRUCTION

Ideally, as an integral part of its installed equipment, the recovery unit should have air conditioning, including temperature and humidity controls. The room temperature should be regulated for 70° F. and the relative humidity between 40 and 60 per cent. Soundproofing will minimize noise from this area. Adequate wall oxygen of the manifold type, as well as wall suction, should be provided. The suction system should be equipped with

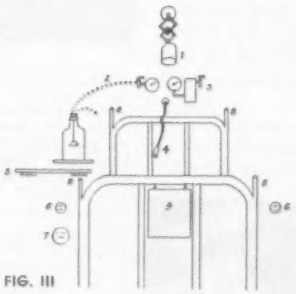

FIG. III

manometric controls and dual pumps. Each suction outlet should be gauge controlled. The oxygen and suction outlets should be located so that they can be reached easily and yet be high enough so that damage by the head of the bed is avoided.

Adequate soft, indirect artificial lighting, which can be adjusted from bright to dim, is desirable. Bed lighting should be of the wall type rather than of the bed-attached type. Wiring should be of such caliber that any reasonable current load can be carried. The fuse box should be wired so that if one fuse is blown, the room is not electrically disabled. Enough electrical outlets should be placed at the proper levels for any possible additional equipment that may be installed. Grounded outlets for various machines (*e.g.* x-ray) should be provided. Wiring for an emergency call system and call buttons should be planned.

The location of telephones should be considered. Telephone bells should be dampened to a hum. Busy telephones should not be able to delay emergency communications. Wiring and electrical equipment for an adequate nurses' station should be established. Allowance should be made for future electrical needs, *i.e.* call buttons, outlets and telephone wiring, so that external wiring and expensive alterations will be avoided. Building codes and fire codes must be followed, of course. (*Cont. on Page 92.*)

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ADRENALIN®

ADRENALIN (epinephrine, Parke-Davis) is today, as it has been for many years, one of the most versatile and useful drugs, known and used the world over. Introduced to the medical profession by PARKE-DAVIS in 1901, ADRENALIN is widely used in many conditions—bronchial asthma, serum sickness, the Adams-Stokes syndrome, and anesthesia accidents.

Circulatory stimulant, vasoconstrictor, resuscitant, and hemostatic, this pure crystalline hormone is one of the truly basic drugs—an invaluable aid in office, in hospital, and in clinic. It is an important adjunct in local anesthesia, valuable in arresting superficial hemorrhage, and a standby for decongestion of engorged mucous membranes.

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MEDICAMENTA VERA

Storage, linen and supply closets, of adequate size and accessibility, should be built into the walls. This will eliminate space consuming furniture type of cabinets. Provision should be made for an ice storage unit and a refrigerator to store blood, plasma and antibiotics. Built-in wall cabinets for firefighting equipment should be constructed. Flooring should be similar to that in the operating room, *i.e.* noninflammable, conductive and easily cleaned. Mobile partitioning by means of easily cleaned, plastic, noninflammable screens or curtains will make the room more adaptable to its various needs. In this fashion, where separate rooms are not feasible, male and female patients can be separated. A patient in extremis can be isolated from the others and necessary visitors thus permitted.

The ideal plan necessitates a large room. The length of the room should be one-half the number of beds multiplied by 6 feet. The width should be approximately 18 feet, so that two rows of beds can be accommodated without beds or furniture having to be moved when a patient's bed is rolled in or out. Doors should be of generous size and of the double-swing, foot-controlled, automatic type. An entrance and exit door should be planned.

Plumbing should provide sufficient quantities of hot and cold water on demand. Disposal units for excreta should be located in a lavatory room which is in immediate proximity to the recovery room.

Collapsible side tables that fold flat against the wall should be spaced so that they will be between beds.

A small sink should be located at the nurses' unit. Also in the room should be two sinks with foot-controlled taps and one generous scrub sink. There should be a narcotic unit with proper locks.

EQUIPMENT

Equipment and supplies for the recovery room are listed as follows:

1. Small instrument sterilizer
2. Sterilizer for bedpans, urinals, emesis basins, and similar receptacles
3. Beds, having the following features: (a) easily adjustable to all standard positions, including Trendelenburg; (b) large conductive rubber casters equipped with brakes; (c) provisions for an intravenous stand for fluids at each corner of the bed. An adapter for the stand can be built in or added by the maintenance crew.
4. Ice storage unit
5. Refrigerator for the storage of blood, plasma and antibiotics
6. Ice bags, hot water bottles, chemical and electrical heating pads (electrical underwriters' approved)
7. Sphygmomanometers, flashlights, stethoscopes, dressing scissors, otoscope, ophthalmoscope and other physicians' supplies
8. Mobile dressing cart with the usual sterile supplies. Cart must be correctly maintained and sterile supplies kept in strict isolation.
9. Tracheotomy set
10. Endotracheal equipment
11. Adequate sterile supplies for nurses: (a) dressings, gloves, gauze, bandages; (b) syringes, needles, thermometers
12. Blankets, covers and linens.
13. Drugs, such as analeptics, sedatives and analgesics
14. Narcotics, placed in the narcotic cabinet and controlled with dual locks and adequate records
15. Provisions for the disposal of dirty dressings via receptacles or bags
16. Type O (universal donor) blood stored for use in acute emergencies
17. Cut-down equipment in sterile sets
18. Sterile nerve block sets
19. Sternal puncture sets
20. Inhalation equipment: (a) means for artificial respiration (mechanical resuscitator); (b) means for administering positive pressure with oxygen; (c) means for providing CO_2 inhalations
21. Deodorizer
22. Side boards and restraining mechanisms
23. Complete nurses' station equipment
24. Charts at the foot of each bed, with complete record located where it cannot be reached by the patient
25. Emergency units for administration of fluids intravenously or intra-arterially under pressure
26. Supplies of sterile fluids, *viz.* saline, distilled water, glucose 5 to 10 per cent
27. Mobile surgical light
28. Special equipment: (a) electric cast cutter, (b) wire cutter, (c) traction bed

PERSONNEL

The present-day conception of care in the immediate postoperative period has been neglected in the average nurses' training program. A high percentage of nurses was graduated five to 10 years ago with little or no attendance at postgraduate nursing courses. Usually they have little conception of present-day knowledge concerning postoperative emergencies. This deficiency must be corrected by individual instruction, if necessary. When a nurses' training school is attached to the institution, a course in postoperative care should be mandatory. Insufficient training is one of the things that has led to the establishment of postoperative care in a recovery room.

Nurses who staff the room should be specially trained and have an insight into the physiology of the postoperative period and a knowledge of the equipment with which they work.

A nurse and an attendant should be present in the room at all times. A doctor who can deal with recovery room emergencies must be available within two minutes. Usually a resident in anesthesia will be available for this call. Should the institution handle a large number of surgical cases or should there be a large volume of special cases, such as thoracic, brain or genito-urinary, a proportionally larger staff will be required.

The attendant should be selected carefully and trained properly. A good attendant can do a large percentage of the work required in the recovery room. The attendant should be of high caliber, young, energetic and willing to work.

A physical examination, including x-rays, Wassermann, and complete blood count, is mandatory on all personnel hired. People with skin disease, upper respiratory infections, and so on should not be permitted to work in the recovery room.

RULES

In order to operate and maintain the recovery room efficiently, rules which are the result of several years' experience have been promulgated. Our experience has shown us that deviations from these rules upset routine, delay emergency treatment, cause the loss of costly equipment, and dissipate responsibility. We urge that the following rules be adhered to as stringently as possible, consistent with the situation in a given institution:

A qualified, capable nurse and an attendant must be present at all times in the recovery room. A designated physician should be available within

a reflection of the expanding scope of therapy...

with the newest of the broad-spectrum antibiotics. A wide choice of dosage forms for a wide range of infections

now available for oral, parenteral and topical therapy

CRYSTALLINE TERRAMYCIN HYDROCHLORIDE CAPSULES
250 mg., bottles of 16 and 100; 100 mg., bottles of 25 and 100; 50 mg., bottles of 25 and 100.

CRYSTALLINE TERRAMYCIN HYDROCHLORIDE ELIXIR*
1.5 Gm. with 1 fl. oz. of diluent.

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CRYSTALLINE TERRAMYCIN HYDROCHLORIDE OPHTHALMIC OINTMENT
1 mg. per Gm. ointment; tubes of ⅛ oz.

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5 cc. vial containing 25 mg. for preparation of topical solutions.

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30 mg. per Gm. ointment; tubes of 1 oz.

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two minutes. If a resident training program in anesthesia is in force, a qualified anesthesia resident should be given this duty. No smoking is permitted in the recovery room. Emergency equipment in the recovery room should not be removed. When an exception is made for a life-saving procedure, the equipment should be returned immediately. All critical equipment, such as tracheotomy sets, suction equipment and fire-fighting equipment, must be inspected regularly. A check list should be compiled so that no item is overlooked. All standard procedures should be typewritten and easily available, so that they can be referred to quickly and followed consistently. Cases of communicable disease, *e.g.* active tuberculosis, erysipelas, must not be permitted in the recovery room.

When a patient is admitted to the room, a doctor must accompany him. Full postoperative orders must be written and given to the nurse in charge when the patient is accepted. The nurse in charge should understand these orders completely and then initial them. The physician who accompanies the patient should write a brief admitting note, which states the operation, anesthetic, course of patient in the operating room, condition of the patient upon leaving the operating room, potential complications, and any other information which may be a guide to postoperative care. Except in a life-saving emergency, telephone orders or verbal orders are not permitted.

Charts must have an entry of at least the temperature, pulse, respiration and blood pressure, at intervals not exceeding two hours. All therapy must be charted. For example, if the patient is turned every half hour, it should be recorded, stating the side to which the patient was turned. Episodes of depression, retching, cyanosis and shock should be noted in detail. When the patient is discharged, an abstract of his course in the recovery room should be entered in the room's permanent record, as well as on his chart. The patient's chart, including x-rays, should accompany him at all times. It should not be removed for any purpose. On arrival and dismissal, the patient and his chart should be identified. No patient is permitted to be sent to his room unless released by designated personnel, as for example, the surgeon, his resident or an anesthesia resident.

Ambulation of patients should not be allowed in the recovery room unless absolutely necessary for therapy.

It may be reemphasized here that no visitors, including parents of children, social workers, librarians and so forth should be permitted in the recovery room except on official business. Just as the public is educated to the fact that visitors are not allowed in the labor room, so must they be educated not to enter the recovery room. An exception is made for the patient in extremis; and in this instance, the patient is isolated.

All standard, correct procedures for nurses and attendants should be followed strictly, *i.e.* reporting to subsequent relieving personnel and giving the pertinent facts, including clinical course and present status.

STAFF RELATIONS

Education of the staff to the peculiar problems of the recovery room promotes cooperation and efficiency. In the three years that the recovery room has been in operation at the Hines Veterans Administration Hospital, there has been no conflict. Everyone has cooperated to the patients' best interests. Primarily, the authority for managing the recovery room is a joint responsibility of the surgical specialty groups and, where available, the anesthesiologist. If a point of conflict should occur, the responsibility should rest with the doctor under whose care the patient is registered.

Knowledge of the purpose and management of the recovery room should be disseminated to all the personnel of the institution. As a result, the recovery room will function more smoothly; and should an emergency arise, the response from all personnel will be prompt and efficient.

FINANCING

To equip and staff a room of this type is not an inexpensive matter. Invariably the objection raised is that the hospital cannot absorb the expense of equipping and maintaining a recovery room and that consequently these expenses must be passed on to the patient, who will object to the added burden. The patient's physician should point out to the patient that for a nominal fee he will receive the benefit of a tremendous safety factor and not only private nursing but specialized private nursing during the period when he needs it most. Also, his hospital stay may be shortened as a result of better nursing care. The patient should understand that the personnel and equipment he commands for this nominal fee would cost many times the fee needed to purchase it separately, that the chances for complications which may lengthen his stay will be less, and that the charge is an equitable one. If the reasons for the additional cost are so presented the objection is usually overcome.

The charge for this service should be set at a minimum. The room should not be operated primarily with the idea of making a profit to defray other hospital expenses. When the actual expenses of the recovery room are calculated (taking into consideration the depreciation of supplies and equipment over a reasonable period), and this expense is divided by the expected number of admissions to the room, the resulting amount should be one to which the patient should have no objection. Of course, the greater the number of patients who utilize the recovery room, the lower the cost per patient. Ideally, the room is a more efficient unit when it is used on a 24 hour basis rather than on a part-day basis. Here again, the degree of utilization depends on the type of institution as well as the volume of cases.

Usually, one-fourth of the fee a patient pays for a private nurse for one day will be enough to pay his recovery room fee.

If the room saves some hospital days for one patient in 10, it will increase the hospital turnover. If it saves one life in 100 or if it increases the patient's safety and comfort, the room proves its worth.

Just as no two hospital administrators find it feasible to use the same criteria for fixing their fees for other services, so it is expected that the basis for recovery room charges will vary. Some institutions will base their charges on the type of room the patient occupies, the type of surgery performed, the duration of stay in the recovery room, or the extent of the service, or possibly a combination of these factors. The standard fees for recovery room service become acceptable to the hospital administration and to the surgical specialty staff if they are discussed by representatives from both bodies before being enacted.

DISCUSSION

We do not intend to create the impression that all the features of a re-

covery room embodied in this paper are an absolute necessity in its establishment. It is conceded that for many institutions prohibitive factors of cost, space and personnel will delay the establishment of any type of recovery room, much less the ideal type of unit which has been outlined. The important point is that the establishment of a recovery room is a step in the right direction and that in its establishment the institution should try to approximate the ideal.

At Hines we almost have attained the ideal, and the arrangement is heartily endorsed by all the services that make use of the recovery room. To summarize, the recovery unit offers an increased factor of safety to the patient during the immediate postoperative period, a more efficient use of material and personnel, and a better training program where there is a nurse or resident training program. It is financially feasible and medically desirable. It works no real hardship on anyone and benefits all.

Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

MECHANISMS OF SKIN WHEAL FORMATION

IN THE Old Testament of the Bible, we read that "There was a man in the land of Uz, whose name was Job; and that man was perfect and upright, and one that feared God, and eschewed evil." The story continues with an account of how the Lord and Satan argued about Job, Satan maintaining that Job's goodness proved nothing, because the Lord had blessed him with riches, power and a large and happy family. To prove that Job really was a good man, the Lord reversed his lot. He allowed Satan to destroy Job's flocks, Job's servants, and Job's children. When Job refused to curse the Lord, Satan smote Job with what were reported as sore boils, but were in fact probably hives, from the sole of his foot unto his crown. Job still remained faithful to the Lord. He took a fragment of a broken crock with which to scratch himself, and sat down among the ashes, for that was in the days before benadryl or cortisone.

It is only within the last 50 years that whealing has received much intensive study. Now after thousands of experiments, the causative factors are still obscure. Probably the most famous line of investigation is that which Sir Thomas Lewis started. In 1927 he introduced the concepts of "triple response" and "H-substance." According to Lewis, the cutaneous wheal is but a part of a complex reaction which follows any of a wide variety of specific and nonspecific stimuli of intermediate intensity. He pointed out that the general nature of the response was the same whether skin was subjected to stroking, heat, cold, histamine, morphine, atropine, nettle stings, insect bites or peptone. In each instance, the skin responded first with a red reaction at the site of application of the noxious agent. This was followed by a red flare surrounding the local reaction, and finally a wheal developed at the local site. Lewis felt that the entire complex reaction could be caused by a histamine-like substance and the normal axon reflex of the skin.

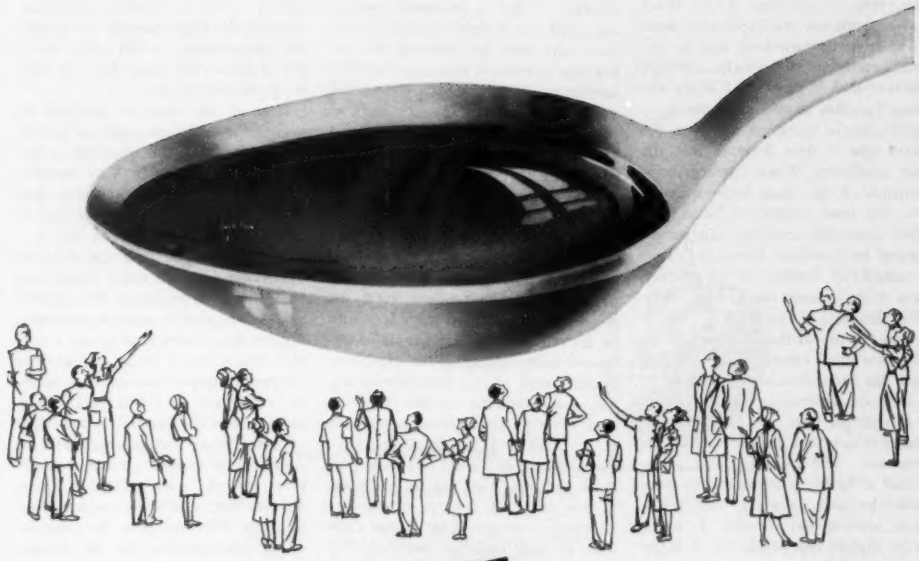
Local injection of histamine into cutaneous tissues causes an extravasation of fluid and protein into the tissue spaces to form a wheal. This is designated as an increase in capillary permeability. The exact nature of capillary permeability has been the subject of numerous investigations.

Anatomical and Histological Considerations. We know that whealing occurs when the capillary wall or membrane becomes abnormally permeable so that the plasma may exude into a localized area. If the condition is general, then giant urticaria or angioneurotic edema occurs.

The capillary is one of the small vessels connecting the arteriole with the venule. These tubes may be divided into true capillaries and arteriovenous bridge capillaries or anastomoses. The capillary lacks smooth muscle, or elastic tissue, and is a hollow tube eight micra in diameter which has only endothelial cells and cement substance for its walls. When stained with silver nitrate, the boundaries of these endothelial cells stand out in sharp contrast. Around the capillary is a layer of connective tissue or reticular fibers which forms a sheath and separates the capillary from other tissue elements. This layer has been called the perithelium. The endothelial cells which contain a single nucleus are known to contract when subjected to a mechanical stimulus.

Functional Considerations of the Capillary Network. Chambers and Zweifach have employed micromanipulative technic in the study of blood flow through the normal capillary bed. These workers report that there is a central arterio-venous channel connecting the smallest sized arteriole with the smallest venule. From this central A-V channel, true capillaries are given off as side branches. Further, there seem to be muscular elements not only in the walls of the smallest arterioles, but also at the necks of the true capillaries to control the amount of blood that flows through the capillary bed. They report that the flow through a given capillary is not steady, but under delicate moment-to-moment control.

They point out that the central A-V channel which they describe, a relatively long, slender vessel, is not to be confused with the A-V anastomoses which have been variously described in the extremities, the wall of the stomach, and the kidneys. These latter anastomoses are short vessels of large caliber, used to shunt large volumes of blood. (*Cont. on Page 98.*)



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When tissue is in a resting or basal state, there is minimal active blood flow through the true capillaries. Most blood from the arteriolar side is carried directly to the venules through the central A-V channels. When the tissue becomes more active, owing to stimulation or irritation, a part of the blood flow is then diverted into the true capillaries. When the metabolic demands of the tissue become excessive, the total amount of blood supplied from the arterioles can be increased by arteriolar dilatation. Thus a remarkably flexible set of mechanisms exists to meet the varying metabolic demands of the tissues.

The Nature of the Capillary Wall. The functional nature of the capillary wall has been extensively studied. As a first approximation, let us picture it as a simple filter. As far as anyone knows it does not actively secrete any substance. The capillary wall is assumed to be freely permeable to small molecules, such as water, urea, potassium, sodium and chloride. It seems to be slightly less permeable to larger molecules like calcium, magnesium and glucose. By this scheme of things it should be completely impermeable to protein molecules, such as albumin with a molecular weight of 69,000 and certainly to fibrinogen with a molecular weight of 500,000. And so by classical theory we account for the passage of water, salts and nutrients between capillaries and tissue spaces on the basis of a gradient between osmotic and so-called "hydrostatic" pressure. Likewise under classical theory we assume that no plasma protein passes the healthy membrane, but under the effects of disease, trauma, histamine, anoxia and so on, the capillary wall is sufficiently damaged that it becomes temporarily permeable to the large protein molecules.

The site of leakage or filtrate is probably at the intercellular cement layer between adjacent cells since the injection of india ink results in a marked accumulation of the carbon particles at this site.

A few years ago Zweifach studied the effects of changes of calcium ion concentration and changes of pH upon the stability of this intercellular cement substance. He found that the cement is more stable in alkaline than in acid environment, and that its production is dependent upon the presence of calcium ion. When he employed calcium-free perfusate, the cement substance was washed away, the capillary walls became leaky, and tissue edema resulted. When a perfusate containing twice the normal amount of calcium was used, he observed the appearance of unusual amounts of cement substance over the entire endothelial surface of the minute blood vessels, as demonstrated by the sticking of suspended carbon particles to the inner surface of the vessels. This observation provides the first justification for the improvement in allergic states after calcium therapy.

Landis has observed that normal capillary filtrate contains small amounts of albumin, globulin and even the huge fibrinogen molecule. It would be convenient to accuse Landis of unintentionally damaging the capillaries in the course of this experimentation, but there remains another explanation. The physical chemists, such as E. J. Cohn and his associates, have examined the molecules of plasma proteins, and find that instead of being in the form of spheres of varying diameters corresponding to the cube roots of their molecular weights, they are in fact in the shape of little cigars of varying lengths, but of relatively constant and small equatorial diameters. The equatorial diameters of all the plasma protein molecules fall in the range of 33 to 38 Angstrom units, according to Cohn. As a corollary to their work, they measured equatorial diameters of molecules of isinglass and pectin, which have been tried as plasma protein substitutes. Pectin and isinglass have diameters in the range from 11 to 18 Angstrom units, and this correlates well with the observed fact that these substances leak out of the circulation in a few hours.

So as a second approximation to the spaces in capillary walls we have the image of the cement substance between cells being composed of a meshwork of pores of many sizes, most of which probably range between let us say 7 and 20 Angstrom units, but with at least a few as large as 38 Angstroms in diameter.

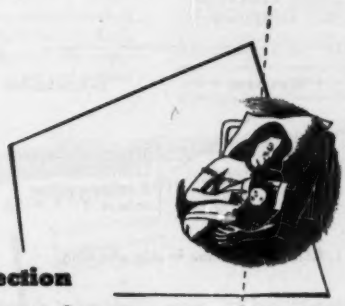
Then comes the problem of the effect of passive stretching of the wall of the capillary on the diameter of these theoretical pores. Both Lewis and Krogh more than 20 years ago felt that capillary distension within rather broad limits has no effect on the permeability of capillaries, so we may assume that these pores will not enlarge with physiological pressure. On the other hand, Zweifach feels that stomata appear between adjacent cells of the endothelium, particularly in dilated capillaries. These stomata are occasionally large enough to permit the extravasation of red cells, which are, of course, far larger than the largest protein molecules.

One of the favorite methods of studying changes in capillary permeability has been the intravenous dye technic, popularized by Valy Menkin. The dye, trypan blue, normally does not pass the capillary barrier, but if the capillary is damaged by any of a number of means, then the dye will extravasate into the tissue spaces and blue wheals are produced. The method has been attacked by some workers who suggest that trypan blue is not a normal constituent of blood, and so what happens to trypan blue does not necessarily happen to the normal constituents. But the method is so simple in both theory and practice, and results so easy to read (if not to interpret) that the technic is still in vogue. Trypan blue is bound to serum albumin and therefore gives the behavior of the albumin molecule. By contrast, the dye sodium fluorescein penetrates readily all tissue spaces and probably gives the distribution of the sodum ion in the extracellular space.

Agents That Produce Whealing Directly. Of the pure chemicals, nicotinyl esters will produce wheals when applied to the intact skin. Numerous agents will produce wheals when applied to the broken skin. Among these are histamine, codeine, morphine, "pontocaine," d-tubocurarine, atropine, pilocarpine, tissue extracts, and venoms. When colloids or detergents are given intravenously the animal or man may have localized or even generalized urticaria. We should emphasize that these are the *known* whealing agents; undoubtedly many others are yet to be discovered.

The similarity between urticaria and artificially induced wheals led many investigators to believe that if a means could be found to neutralize, block or antagonize the action of histamine on blood vessels, it could be used to treat clinical urticaria, as well as a number of other allergic conditions, which were believed to be mediated by histamine or an H-substance. (Fig. 1.)

The attack upon histamine proceeded along several avenues. A number of workers have given allergic patients hypodermic injections of histamine in increasing doses in an attempt to increase their tolerance to the substance. The results of this form of



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1. Winnell, G. B., Canad. M.A.J., 53:555, 1945.

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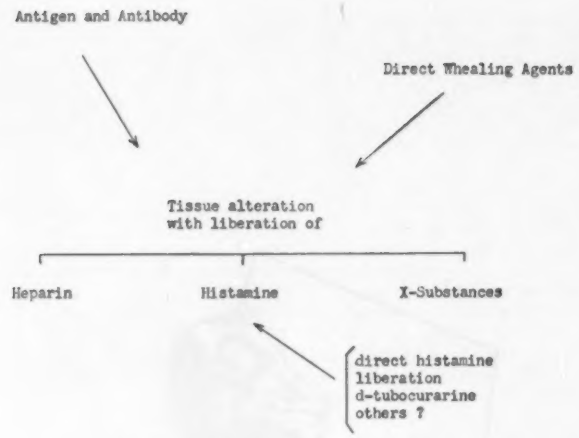

Fig. 1. Rôle of histamine in skin whealing.

treatment have been equivocal and, in many instances, in direct proportion to the enthusiasm of the investigator.

The enzyme histaminase has been tried clinically and found wanting. Though the enzyme is effective in inactivating histamine *in vitro*, its *in vivo* use has been almost uniformly disappointing.

The most successful attack on histamine has been by means of the now famous antihistamine drugs. These agents have been found to protect normal guinea pigs against lethal doses of histamine; they protect sensitized guinea pigs against anaphylactic doses of antigen. They diminish the size of wheals produced by histamine, peptone, morphine, atropine and so on in normal individuals, and the size of wheals produced by specific antigen in sensitive persons. They reduce swelling and congestion in a number of clinical conditions.

Daniel Bovet has defined an antihistamine substance as a counterpoison, having no specific activity of its own on the normal animal, its properties appearing only when it can manifest a blocking effect against histamine.

In 1944, a number of workers investigated a series of chemical compounds for their antihistamine effect. From this work came benadryl, neoantergan, pyribenzamine, and thephorin which were highly effective in the hands of the laboratory scientist.

Paralleling the experimental investigation, the clinical investigation of the antihistamine agents moved ahead with leaps, bounds and enthusiasm. Hay fever, vasomotor rhinitis, asthma, urticaria, poison ivy, and creeping itch patients were dosed with the drugs, and the clinicians were pleased with the observed results. The *Readers Digest* and the daily newspapers announced the arrival of the Therapeutic Messiah.

Then, in the cold gray light of the morning after, the inevitable occurred. With our new knowledge, our even greater ignorance became apparent. Just as the study of histamine had led to the search for antihistamine agents a few years before, the development of the antihistaminics prompted a reconsideration of the nature and functions of histamine in the human organism. It turned out that there were a few wide gaps in our knowledge.

It is generally agreed that histamine will produce changes in the caliber and permeability of small blood vessels. Likewise, changes in caliber and permeability of blood vessels can produce the signs and symptoms of urticaria, hay fever, and vasomotor rhinitis. These disease conditions can be treated with antihistaminics, with symptomatic relief in a large percentage of cases. It has been pointed out that this argument is largely one of analogy, and does not cover all known facts.

One disturbing experiment was performed by Schild in 1936. This investigator suspended the isolated horn of the uterus of a sensitized guinea pig in a bath and treated it with histamine in a concentration to cause maximum tonic contraction. He waited until, with the histamine still present, the smooth muscle eventually relaxed from its maximum to a condition of intermediate tone with a strong rhythm. Further addition of histamine to the bath had no effect or even caused relaxation. However, addition of the antigen to which the guinea pig had been sensitive caused the sensitized uterus to undergo maximum contraction again. Now, the antigen-antibody reaction has been assumed to be mediated by the release of endogenous histamine from the sensitized tissue. But in Schild's experiment the antigen gave the response which further histamine could not elicit when added directly to the bath.

Another experiment carrying a similar implication was reported a few years ago. The workers constructed a chain of rings from the tracheal cartilage of a sensitized guinea pig. When exposed to histamine or specific antigen, the rings contract and the chain becomes shorter. The contraction caused by histamine is readily relaxed with benadryl, while that caused by specific antigen is relaxed but slightly by that drug.

Mosko and Marshall became distressed by the failure of antihistamine drugs to benefit certain patients suffering from chronic urticaria and angioneurotic edema, and so they studied the effects of several drugs on experimentally induced wheals. They demonstrated that the antihistamine agents, pyribenzamine and histadyl, would indeed inhibit the formation of wheals by histamine and ragweed extract, if the antihistaminics were given first. However, the antihistamine seemed to have little effect upon preformed wheals. Of the drugs they studied, only ephedrine, epinephrine, isuprel, and aminophyllin produced any regression of preformed wheals.

Sir Henry Dale has pointed out that one possible explanation for such seeming inconsistencies as these may be found in the relationship between drug and the limiting membrane of the reacting cell. He states that when we are dealing with antagonisms, wide differences may be encountered between effects which are otherwise similar, according to whether a pharmacodynamic agent reaches the responsive cell by diffusion from without or by liberation in intimate relation to, perhaps actually within, its limiting membrane.

Urbach and Dragstedt have provided the most valid evidence that

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PARTIAL LIST OF THERAPEUTIC AND PROPHYLACTIC INDICATIONS

Actinomycosis	P
Anthrax	P
Arthritis—Pyogenic	P
Brucellosis	D S
Burns	P
Carbuncles	P
Cellulitis	P
Chancroid	P S
Cystitis	P D S
Diphtheria	P
Empyema	P D S
Endocarditis—Bacterial	P D S
Epididymitis	P
Erysipeloid	P
Furunculosis	P
Gas Gangrene	P
Gonorrhea	P D S
Granuloma Inguinale	D S
Intestinal Surgery (Prophylactic Use)	D S
Leptospirosis	P
Ludwig's Angina	P
Mastoiditis	P
Meningitis	P D S
Meningococcemia	P
Osteomyelitis	P
Otitis Media	P
Peritonitis	P D S
Pharyngitis	P
Puerperal Sepsis	P S
Pulmonary Infections	P S
Pyelitis	P D S
Pyelonephritis	P D S

Rat-bite Fever	P
Relapsing Fever	P
Scarlet Fever	P
Septicemia	P
Spirochetosis	P
Streptococcemia	P
Suppurations	P
Syphilis	P
Tetanus	P
Thrombophlebitis	P
Thrombosis—Sinus	P
Tonsillectomy (Prophylactic Use)	P
Tonsillitis	P
Tooth Extraction (Prophylactic Use)	D S
Tuberculosis	S
Tularemia	P D S
Urethritis	P
Vincent's Infection	P
Wounds—Infected	P

P = Crystalline Penicillin G Sodium Merck
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Crystalline Procaine Penicillin G Merck in Oil Containing 2% (w/v) Aluminum Monostearate
or
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(Crystalline Procaine Penicillin G and Buffered Crystalline Penicillin G Potassium for Aqueous Injection)

D = Crystalline Dihydrostreptomycin Sulfate Merck

S = Streptomycin Calcium Chloride Complex Merck

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histamine is not the only chemical liberated in anaphylaxis and hence by inference in the whealing reaction. Using paper chromatography on the plasma from dogs in anaphylactic shock these workers have found two distinct chemicals to be present—only one of which is histamine.

Is Cortisone an Antidote for the Unknown Tissue Factor? Valy Menkin has long been a leader in what might be termed the "t'ain't-all-histamine" school. He has taken the cell-free exudate from sterile abscesses and demonstrated that this exudate is capable of increasing capillary permeability to the point that trypan blue will extravasate and wheals will form. By purifying the cell-free exudate, Menkin obtained an active principle which he has called "leukotaxin." Not only does it increase the permeability of the capillaries, but also it causes the migration of leukocytes to the site of injection. Menkin believes that leukotaxin is entirely free of histamine.

Looking for substances that would antagonize the action of leukotaxin, Menkin tried adrenal corticoids. This is particularly interesting because he did this 10 years ago, before the world had taken up the Gospel according to ACTH. Menkin showed that adrenal cortical extract would prevent hyaluronidose action and would largely or completely prevent the extravasation of trypan blue induced by leukotaxin or the crude cell-free extract. Freed and Lindner continued along the same line and showed that crude extract of adrenal cortex and corticosterone. which is the carbohydrate and nitrogen regulating fraction of the extract, were active in antagonizing leukotaxin, while other hormones including desoxycorticosterone acetate, estrone, stilbesterol and progesterone did not antagonize it.

More recently Harris and Harris have shown that cortisone will reduce the tuberculin reaction in guinea pigs; Jones and Meyer and others have demonstrated the same for a non-specific inflammatory reaction, both the "arthus" and "Schwartzman" phenomena are inhibited, and we know that both cortisone and ACTH give symptomatic relief in allergic states.

Perhaps as this work continues we will be able to synthesize from our relatively isolated observations a more nearly complete and satisfactory picture of the whole process. One interesting suggestion has come from the work of Reed and Joseph at the University of Illinois. They feel that in arthritis at least, there seems to be some connection between the C_{11} corticoids and the glucose-glucoseamine balance. Glucoseamine in turn is a building block contained in the semi-mysterious hyaluronic acid which is reputed to play a rôle in cementing together contiguous cells. So, one view of increased permeability could be that leukotaxin, histamine or unknown substances attack the cement between cells, and marginal leaks occur. Cortisone in turn may act to make available to the cells glucoseamine, from which cement substance can be built to tuck-point the leaks and reinforce the seams. But now we are really out on the fringe of things, so we had best wait until more experiments are available to back up this flight of fancy.

As we have seen so often, any disease or bodily process whose mechanisms remain unclear is eventually taken over by our friends, the psychosomaniacs. And so it has been with urticaria. For years we have been told that urticaria is in truth weeping under the skin. It has been demonstrated that changes in cutaneous blood vessels do occur during emotional changes, but that this is sufficient to account for the development of wheals is a different story, and opinion is by no means unanimous.

Most recently, Graham and Wolf (as did Lewis and others before them) have suggested that the cutaneous changes in urticaria are quite indistinguishable from the changes caused by the forceful application of a whip or a lash. They found in a series of 30 cases that the attacks of urticaria were correlatable to emotional disturbances of a very specific kind. Each of their patients was in a life situation in which he felt resentment because he saw himself as a victim of unjust treatment about which he could do nothing in retaliation. He just had to stand there and take the beating. The urticaria then was the very real welts from symbolic beatings.

But this is where we came in. For was that not Job's life situation? He was certainly unjustly treated, but being a God-fearing man, he could not fight back. So, he developed urticaria, from the sole of his foot unto the crown of his head. And this three-thousand-year-old observation should spur us on to elucidate the other unknown factors in the whealing reaction.—HENRY H. SWAIN, B.S., and C. C. PFEIFFER, M.D.

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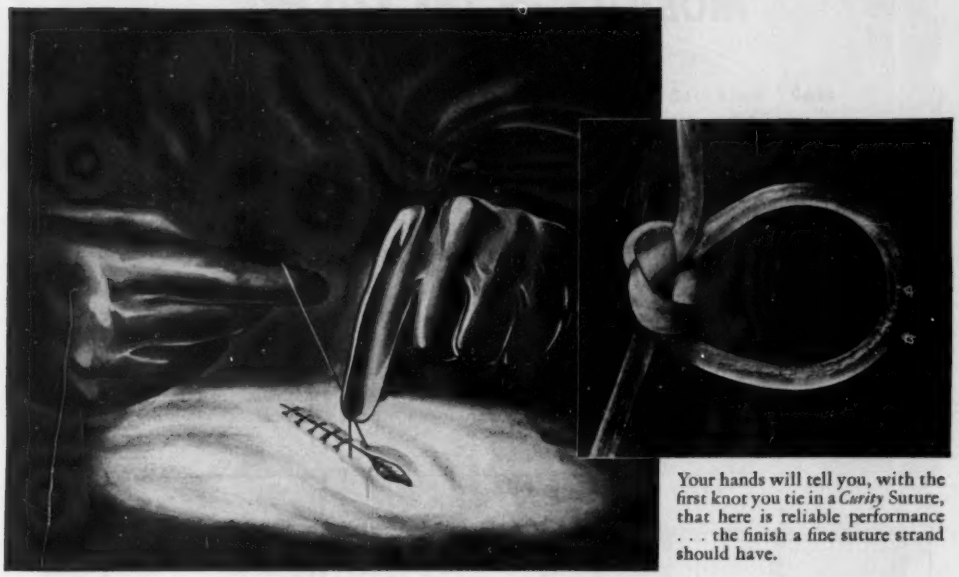

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MOBILITY IN THE KITCHEN

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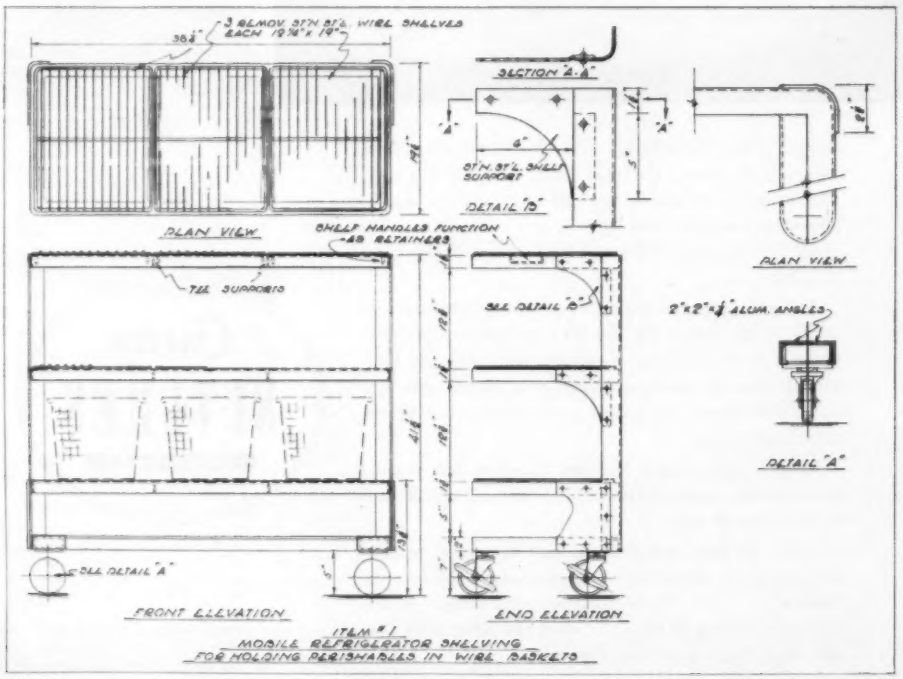
Head, Institution Management
Teachers College, Columbia University

OWEN WEBBER
Consulting Engineer
New York City

TEACHING in institution management at Teachers College, Columbia University, is integrated with the practical operation of the food service for students. In order to meet increasing costs it became essential to devise methods for increasing efficiency of personnel. One of these methods, used in connection with a course in equipment, was to place on wheels certain items of equipment which are frequently fixed. Drawings of three of these items are given here in the belief that others may find them useful. They can be made by any good fabricator and modified to suit individual needs.

Each item is a type of portable shelf cart which is used in walk-in refrigerators instead of fixed shelving. Loading refrigerators having fixed shelving requires loading a truck at the point of delivery, wheeling the truck to the door, and carrying the material from the truck to the shelves. The same items have to be reloaded for distribution to the kitchen departments as needed. Portable shelves, on the other hand, are wheeled to point of delivery for receiving the food, then into refrigerators or to the vegetable preparation unit and to cooking or service areas. Portable shelving is easy to clean and



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Left: Mobile refrigerator shelving for holding perishable foods. Dollies to hold egg crates slide under the shelves. Right: Portable stainless steel milk truck.

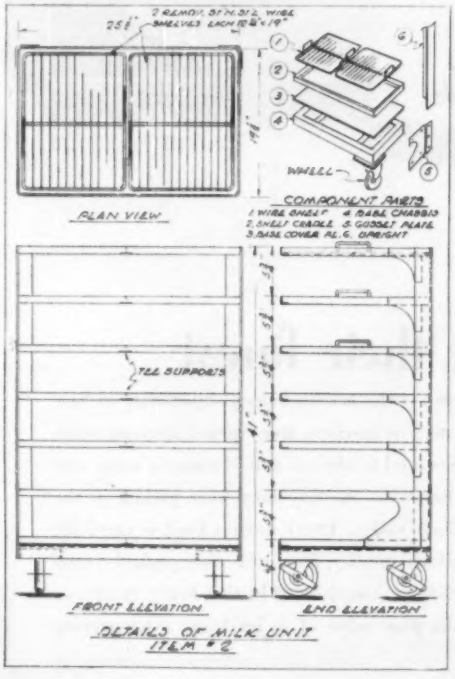
permits easy cleaning of walls and floors. It makes possible maximum use of the refrigerated space and minimizes labor.

The chassis, vertical members, and shelf cradles of all items are constructed of aluminum in order to lighten the equipment. Additional strength and rigidity are achieved by introducing stainless steel gusset pieces which supply the necessary support and horizontal stability. Shelf cradles are bracketed to vertical rear members, thus eliminating front support and permitting easier access.

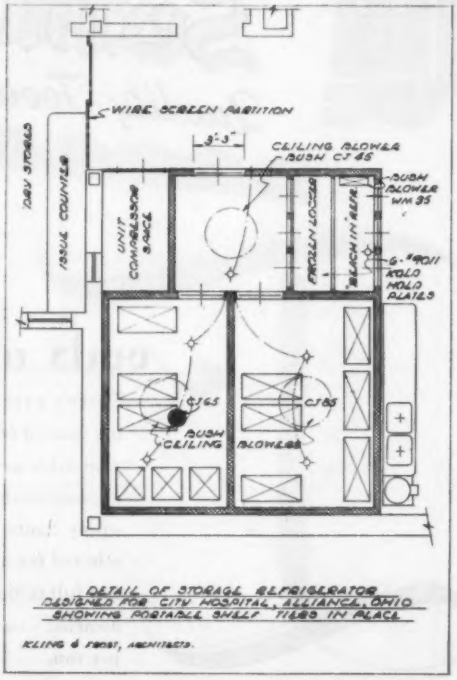
All items are readily maneuverable. Wheels are equipped with ball bearing seats and easily operated brakes, and with rubber tires of a size which afford a long life of operation.

Item 1 is made with either two or three shelves. Item 2 has seven shelves. Shelves for Items 1 and 2 are of sturdy stainless steel wire assembled accurately. They are held in position by stainless steel pegs and are readily removed and cleaned.

These shelves are designed as multiple units of the same over-all dimensions in order to minimize manufacturing costs. Two sections are used on each shelf of Item 1. The slight bend in the outside wire at the ends permits the use of the section as a tray, if desired. One section is used to each shelf of the milk truck. It holds one case of milk cartons and fits the slides of the service refrigerator to which the milk is transferred as needed. Shelves in the photograph of a similar item are of aluminum with edge turned up one-half inch. They are designed to hold two trays without waste space. Wire baskets for holding vegetables on Item 1 are approximately 14 inches wide by 18 inches deep by 10 inches high. No space is wasted. The frame for the top of the dolly,



DETAILS OF MILK UNIT ITEM #2



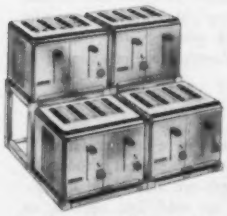
DETAIL OF STORAGE REFRIGERATOR DESIGNED FOR CITY HOSPITAL, ALLIANCE, OHIO SHOWING PORTABLE SHELF TILES IN PLACE

KLING & FROST, ARCHITECTS

Whatever your hospital's size there's a TOASTMASTER *toaster to suit your needs!*

"Of course... it's Electric!"

4-SLICE MODEL 1D2
Toasts over 250 slices per hour.
$99.50† Fair Trade Price.
(Fed. Excise Tax Incl.)



†*Price subject to change.*

WHETHER YOU HAVE hundreds of patients to feed or relatively few, there's a "Toastmaster" Toaster that exactly fits your needs. Take your choice of six sizes that pop up from 125 to 1000 slices per hour—from 2 to 16 slices per minute!

SO, YOU NEVER pay for more toasting capacity than you need. There's no time lost either in pre-heating, no burned toast to remake, no wasted bread. For every slice is perfect every time. The "Toastmaster" Toaster is completely automatic, uses current only while toasting... and each pair of slots is individually heated to save you still more in operating cost.

THIS TOASTER is especially designed internally for rugged, day-after-day institutional use. Outside, its thick chromium-plated finish is durable and easy to keep spotlessly clean.

YOU'LL BE GLAD to learn how much time and how many steps can be saved by putting a "Toastmaster"® Toaster on diet-kitchen service. Every day, more and more hospitals are discovering that this results in less time spent on food service—more, on other tasks. Call your food service equipment dealer, now.

TOASTMASTER
AUTOMATIC POP-UP TOASTERS

®"Toastmaster" is a registered trademark of McGraw Electric Company, makers of "Toastmaster" Toasters, "Toastmaster" Waffle Bakers, "Toastmaster" Roll and Food Warmers, and other "Toastmaster" Products.
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A Toaster for every Hospital Need!

FOR THE MAIN KITCHEN... The 16-slice, Model 4-1D2-D (above), is ideal for larger hospital main kitchens. That's because it has plenty of toasting capacity—pops up over 1000 slices per hour!

$410.00† Fair Trade Price.
(Fed. Excise Tax Incl.)

FOR THE DIET KITCHEN... The 2-slice, Model 1BB4 (right), is perfect for diet kitchens. It pops up over 125 slices of toast per hour. Equipped with cord to plug into any wall outlet.

$52.00† Fair Trade Price.
(Fed. Excise Tax Incl.)

Dept. G-11
TOASTMASTER PRODUCTS DIVISION
McGraw Electric Company, Elgin, Ill.

☐ Send me complete information on "Toastmaster" Toasters.
☐ Send me complete information on "Toastmaster" Roll and Food Warmers.

Name.....
Institution.....
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City.....*Zone*.....*State*.....
My Dealer's Name.....

Item 3, is an aluminum angle, with the top plate of 16 gauge stainless steel. Dollies are used for egg crates, milk cartons and similar articles and slide under the bottom shelf of the two-shelf truck.

In order to use portable shelving the threshold of the refrigerator must be flush with the floor outside. This may be slightly more expensive than the old type of insulation and finish on top of the floor slab, but it is warranted when one considers the tons of food stuffs which pass through the refrigerator doors each year, and the life of the equipment.

The door bucks of refrigerators are flared and rabbeted to provide gasket seating and prevent air leak. To leave adequate clearance for convenient guidance of portable shelf units in and out of the refrigerators, a finished door opening of 3 feet 3 inches is suggested.

FOOD FOR THOUGHT

Low-Cost Proteins

Dry skim milk, soybean flour and food yeasts are three low-cost high-protein foods which can be combined successfully with cereal foods to improve the nutrition especially of low-cost diets, according to Dr. Barnett Sure of the Arkansas Experiment Station. Dr. Sure points out that cereal grain foods are the cheapest sources of calories and are consumed in largest proportion by people of low-income levels. Though grains contain some protein, this needs to be supplemented by high-quality protein, such as milk, meat and eggs provide.

Dr. Sure says the need for more protein may be much more extensive than has been supposed. Adequate protein is needed for growth and also upkeep of the body—for growing children and for adults and the elderly. Even small quantities of high-protein food combined with cereal grain products would improve nutrition in many families.

In studying possibilities of enriching popular dishes with low-cost protein, Dr. Sure found the food yeasts promising. He reports that these yeasts, used to the extent of 1 to 3 per cent, in macaroni and cheese, Spanish rice, chicken pie, soups, gravies, hot rolls and biscuits, cakes, cookies and sandwiches, were successful in dining halls and cafeterias of the University of Arkansas and in a near-by veterans' hospital.

Dr. Sure has developed a low-cost, high-protein food as a meat extender. Composed largely of dried milk, it is supplemented with soybean flour, vegetable shortening, calcium and iron salts and five important vitamins. It proved successful in more than 3000 test meals served to college students, school children, and others. Palatable dishes prepared with it were: hamburger-like patties, meat loaves, chili con carne, ravioli, chicken loaf and pimiento-pickle loaf for cold slicing.

Some prepared breakfast foods already are being enriched with yeast protein, Dr. Sure says. Others contain soybean flour. Many commercially prepared foods could include these low-cost proteins, he says.

Breakfast Juices

Chilled juices, popular first course at breakfast, are tangy waker-uppers that go well with the hot dishes on most morning menus. And some juices —if the portions are generous—do important duty in providing much of the day's vitamin C.

If you rely on fruit juices for vitamin C, it's well to check your choice for its vitamin C content, say nutritionists of the Bureau of Human Nutrition and Home Economics, U. S. Department of Agriculture. Rich in this vitamin is fresh orange juice, they point out. But all citrus juices rank high—frozen and canned orange juices, and the various forms of grapefruit and tangerine juice.

Tomato juice is another good source of vitamin C, but unless it is fortified with added vitamin C, it takes more than twice as much canned tomato juice to match canned orange juice. Pineapple juice has much less of this vitamin, and only traces—unless the juice is fortified—are to be found in apple, prune or grape juice, all popular for flavor and variety. Extra vitamin C is sometimes added to apple juice and other canned, bottled and frozen juices which are short on it. These fortified juices may have as much or more vitamin C as citrus, the nutritionists explain, but be sure to check the label.

If your breakfast juice is short on C, be sure to get this vitamin in some other dish or later in the day. Vitamin C—ascorbic acid—is one of the essentials for keeping tissues in good condition. It is needed daily because the body can't store much of this vitamin.

Among other dishes rich in vitamin C are the fruit itself of citrus and tomatoes which can be served many ways in any meal. Excellent sources of ascorbic acid are strawberries, kale, turnip greens, broccoli, raw cabbage, green peppers, and the dark-colored raw salad greens. Good providers are lightly cooked cabbage or collards, cantaloupe, sweet potatoes, cauliflower and spinach.

Don't confuse diluted "ade" drinks with juice concentrates which you restore to natural strength with water. Fruit drinks diluted with water which come in cans, bottles or cartons may be refreshing for between-meal snacks but usually don't provide much vitamin C. If water is named first in the list of ingredients on the label, there's more of it than fruit juice in the mixture. Powdered fruit-flavored drinks, which require added water, are usually synthetic, as you can tell from the label, and therefore are not vitamin C providers.

Turkeys

Turkey hens were once preferred to toms. But under present production methods, both are tender and meaty.

Turkeys are sold live, dressed, or ready-to-cook, and wise buyers should consider price accordingly. A dressed turkey has been bled and picked but not drawn, and head and feet have not been removed. Ready-to-cook birds are fully drawn or eviscerated; pinfeathers have been removed; the bird has been thoroughly cleaned inside and out, and the cleaned giblets and neck are packed in the cavity.

THANK YOU, LADIES & GENTLEMEN!

THE VOLUME OF PROLON WARE PURCHASES placed throughout the country by wholesalers, institutions, hotels and restaurants has been gratifying proof that you appreciate the many points of superiority we have incorporated into this new line of tableware. We are happy, and grateful, that you have shown such marked and instant approval of Prolon Ware's balanced design, its outstanding "Prolon Glaze," and its range of 17 items in a choice of four pleasant colors.

Prolon Ware... a product of **PROLON PLASTICS**, a division of

PRO-PHY-LAC-TIC BRUSH COMPANY FLORENCE, MASS.

MOLDERS OF FINE PLASTICS SINCE 1844

NATIONAL DISTRIBUTOR, Parker D. Perry, Incorporated, 729 Boylston Street, Boston, Mass.

Dressed birds come higher per pound than live birds; ready-to-cook are higher than dressed. But the actual cost per pound is about the same for all three when the bird is ready for cooking. Money spent on live or dressed birds buys more waste. The ready-to-cook birds save the most time in the kitchen. Thus, the buyer can afford to pay about a fifth more a pound for a ready-to-cook turkey than for a dressed turkey.

For Skillet or Broiler

Fried turkey may one day vie in popularity with fried chicken on American dinner tables, poultry specialists of the U. S. Department of Agriculture believe. Specialty markets in various parts of the country have been offering small supplies of turkey fryers for several years and have reported that customers literally gobbled them up, even at prices above those of frying chickens. Fried turkey dinners served by poultry associations have been enthusiastically received by guests.

Growers could produce these young birds the year round, as broiler chickens now are produced, if there was sufficient demand to make the business pay.

Here are cooking suggestions from specialists of the U.S. Department of Agriculture and some hotel chefs who have cooperated with them. Best for frying or broiling are birds about three months old of the smaller varieties having inconspicuous pinfeathers. These are split for broiling or disjointed for frying. Because thigh and breast pieces are larger than in chickens, they may be divided for cooking. Turkey fryers are cooked just like frying chicken, the time being adjusted to size of pieces. Pieces may be rolled in flour seasoned with salt, pepper and a bit of garlic salt, if desired, then browned in shallow fat in a pan on top of the stove and finished uncovered in a moderate oven.

Turkey has its own rich flavor, whether it is roasted, broiled or fried. A fried turkey dinner, therefore, may be a special treat for company—something new as well as delicious and hearty, which may one day take its place on poultry counters at all seasons of the year.

Freezer Alarm Bulb

The sensitive "bulb" that sets off the alarm in the freezer has a proper location, one that provides an early warning when precious pounds of frozen foods are in danger of spoilage. To freezer owners who buy a freezer without an alarm, U.S. Department of Agriculture scientists recommend placing the bulb against the back liner of the freezer at a point level with the top layer of cartons if the freezer is fully loaded.

In testing different locations, scientists found that the bulb placed in this spot at the top of the back liner gave a warning in good time—before the temperature had risen much and the food had begun to soften. When placed in other parts of the freezer, the alarm bulb did not signal the owner soon enough to save the stored food.

Dr. Earl McCracken and Marilyn G. Fisher of the Bureau of Human Nutrition and Home Economics conducted the tests, checking the reaction of nine different alarms when temperatures began to climb. Their findings differ from the directions of alarm manufacturers, who suggest such varied locations as the bottom of the freezer, the back wall, or the lower half.

In the chest type of freezer with more than one compartment, the scientists advise placing the bulb in the storage compartment farthest from the compressor, but in a vertical freezer they advise placing it in the top compartment. Again, the top of the back liner in the compartment is the best place for the bulb.

Alarms are essential for warning when power goes off, the freezer mechanism fails, or the load of food being frozen is too much for the freezer.

Preserving Pie Plant

Freezing is a far better way to preserve rhubarb for year-round use than is "putting it down in water"—or uncooked canning, according to the New York State Experiment Station.

The customary way to preserve rhubarb or "pie plant" in many northern areas is to cut the stalks in pieces, place them in fruit jars, run in water, cover the jar and store in the basement—with no cooking. This is a simple method of preservation but rhubarb packed and stored this way is inferior in flavor and other qualities to that preserved by freezing, tests at the station proved.

Rhubarb was prepared for freezing in four different ways. After the stalks had been washed and cut in inch pieces, one lot was simply put in cartons and frozen. Another lot was scalded in boiling water 1½ minutes, cooled, packaged and frozen. A third lot was scalded, then covered with sirup before being packaged and frozen. The fourth lot was cooked in sirup before being packaged and frozen.

After six months at 0° F. the uncooked lots were cooked and the precooked frozen rhubarb was thawed before being served to the judges. The rhubarb put down in water was made into sauce. The judges agreed that all the frozen samples were superior to the rhubarb put down in water.

Though most home freezing specialists recommend treating rhubarb with hot water or steam before freezing, the New York State scientists say that rhubarb is one of the few products in the vegetable class which can be frozen satisfactorily without a heat treatment —perhaps because of its acidity.

Protecting Electric Appliances

Turn off the appliance before pulling out the plug, specialists of the Rural Electrification Administration, U.S. Department of Agriculture, remind us.

This is a simple but important rule to prevent damage both to the plug on the electric cord and the convenience outlet in the wall. It holds for appliances large and small, from washing machines and vacuum cleaners to toasters and heaters, and even to portable lamps.

Pulling the plug when an appliance is running or heating shuts off the flow of electricity gradually so that it sparks or makes an arc between the prongs of the plug and the wall outlet. This burns the prongs, leaving them pitted, rough and dark. Then they cannot make a good contact and eventually will bring in no electricity at all. It also may burn the contacts in the outlet.

But turning off the appliance by its own switch makes an immediate, clean cut-off in current, and then the plug may be removed safely with no danger of sparking or burning.

The specialists say, however, that some few electric appliances are not provided with their own switch. For these the rule is: Pull out the plug as fast as possible when you are disconnecting it.

As for portable lamps, it pays to turn out the light before pulling the plug from the wall when it is necessary to move them.

Menus for February 1951

Helen Phillips
Dietitian
Randolph Hospital
Asheboro, N.C.

1 Grapefruit Halves Crisp Bacon Curls • Broiled Pork Chops Mashed Sweet Potatoes Turnip Greens Sliced Cucumbers Apple Cobbler • Escalloped Potatoes and Ham Buttered Asparagus Raw Carrot Strips Canned Blackberries	**2** Orange Juice Fried Eggs, Toast • Baked Halibut Fillet Mashed Potatoes Buttered Carrots Vegetable Salad Butterscotch Pudding • Salmon Loaf Stewed Corn Head Lettuce Salad Toasted Rolls Peaches and Cream	**3** Stewed Prunes Scrambled Eggs • Stew Beef and Vegetables Relish Plate Corn Sticks Chocolate Pie • Oyster Stew Pear and Orange Salad Toasted Cheese Sandwiches Apple Betty	**4** Sliced Bananas Muffins with Preserves • Fried Chicken Rice and Gravy Green Beans Spiced Peaches Ice Cream • Assorted Cold Cuts Potato Chips Celery Curls, Radish Roses Tomatoes and Lettuce Hot Chocolate Cookies	**5** Tomato Juice Poached Eggs • Roast Pork Blackeyed Peas Buttered Squash Snow Pudding • Beef-Vegetable Pie Stewed Corn Toasted Rolls Gelatin Custard Sauce	**6** Orange-Grapefruit Sections Hot Cakes, Sausage • Veal Cutlet Mashed Potatoes Field Peas and Snaps Turnip Greens Cherry Cobbler • Salisbury Steaks Rice and Gravy Tiny Green Peas Peach-Cottage Cheese Salad Lemon Sherbet
7 Pineapple Juice Scrambled Eggs, Bacon • Smothered Chicken Buttered Potatoes Green Beans Celery and Olives Hot Rolls Ice Cream • Cream of Tomato Soup Ham Salad Sandwiches Mixed Fruit Salad Cookies	**8** Orange Halves Fried Eggs • Country Style Steak Pan Browned Potatoes Buttered Spinach Waldorf Salad Chocolate Pudding • Cheese Rabbit on Toast Broccoli Tomato Salad Tapioca Pudding	**9** Fried Apples Sausage • Fried Fish Escalloped Potatoes Green Beans Coleslaw Lemon Custard • Escalloped Corn and Bacon Lima Beans Head Lettuce Salad Peach Halves/Cream	**10** Fresh Grapes Chicken Giblets on Toast • Roast Beef Creamed Potatoes Peas and Carrots Sweet Mixed Pickles Boysenberry Cobbler • Spaghetti and Meat Balls Mixed Vegetable Salad French Rolls Fruit Cup	**11** Stewed Prunes Baked Eggs, Toast • Baked Chicken With Dressing Candied Yams Green Peas Cranberry Sauce Plum Pudding, Hard Sauce • Boiled Ham Potato Salad and Pepper Rings Sliced Tomatoes Loaf Bread Lemon Cup Cakes	**12** Grapefruit Halves Scrambled Eggs, Bacon • Baked Spareribs Mashed Sweet Potatoes Sauerkraut Apple and Carrot Salad Rice Pudding • Chicken à la King Buttered Asparagus Shredded Lettuce, French Dressing Apricot Halves
13 Tomato Juice Sweet Buns • Country Style Steak Mashed Potatoes Turnip Greens Tomato Aspic Salad Plain Cake With Chocolate Sauce • Cream of Chicken Soup Egg Salad Potato Chips Pickle Relish Peach Halves	**14** Blended Fruit Juices Bacon • Chicken Pot Pie Succotash Celery Curls Red Gelatin Heart Molds • Creamed Chipped Beef on Toast Green Beans Pear and Banana Salad Ice Cream	**15** Hot Apple Sauce Scrambled Eggs, Bacon • Spanish Rice Blackeyed Peas Steamed Cabbage Grapefruit and Apple Salad Coconut Pie • Ham With Broiled Pineapple Slices Stewed Corn Asparagus Salad Hot Biscuits Baked Custard	**16** Sliced Bananas Toast, Preserves • Salmon Loaf Buttered Potatoes Broccoli Carrot Salad Apple Cobbler • Spaghetti With Tomato Sauce Green Peas Tomato Salad Fruit Compote	**17** Orange Juice Ham and Grits • Roast Veal Parslied Potatoes Escalloped Tomatoes Tossed Green Salad Lemon Sherbet • Vienna Sausages Broiled Apple Rings Potato Sticks Sweet Pickle Strips Chocolate Pudding	**18** Assorted Juices Hot Cakes, Sausage • Fried Chicken Candied Yams Buttered Sweet Peas Spiced Pears Hot Rolls Strawberry Shortcake • Vegetable Soup Toasted Cheese Sandwiches Prune and Orange Salad Assorted Small Cakes
19 Prune Juice Soft Cooked Eggs • Stew Beef White Beans Buttered Squash Coleslaw Peach Cobbler • Hamburger Loaf Creamed Rice Buttered Asparagus Sliced Tomatoes Bread Pudding	**20** Orange Halves Sausage, Toast • Roast Pork Baked Sweet Potatoes Turnip Greens Raw Carrots Cheese Apple Crisp • Canned Meat With Raisin Sauce Escalloped Potatoes Tomato Aspic Salad Fruit Gelatin Custard	**21** Tomato Juice Fried Eggs, Bacon • Chicken Croquettes Stewed Corn Green Beans Yeast Biscuits Ice Cream • Roast Beef Green Peas Escalloped Tomatoes Head Lettuce Salad Prune Plums	**22** Sliced Bananas Muffins, Preserves • Broiled Liver Mashed Potatoes Tossed Green Salad Cherry Cobbler • Purée of Chicken and Rice Hot Apple Sauce Green Beans Shredded Lettuce Peach Halves With Cream	**23** Grapefruit Halves Scrambled Eggs, Bacon • Macaroni and Cheese Hashed Browned Potatoes Blackeyed Peas Radishes Coconut Pie • Tuna Fish Salad Harvard Beets Lima Beans Banana Pudding	**24** Stewed Prunes Toast and Jam • Pork Chops Candied Yams Waldorf Salad Chocolate Pie • Corn Pudding With Bacon Green Peas Pineapple and Cottage Cheese Salad Fresh Grapes
25 Orange Juice Toasted Doughnuts • Fried Chicken Mashed Potatoes and Gravy Green Beans Celery Curls Ice Cream • Cold Cuts Tomatoes and Lettuce Potato Salad Cream Cheese and Jelly Cookies	**26** Tomato Juice Soft Cooked Eggs • Beef and Vegetable Pie Parslied Potatoes Head Lettuce Salad Chocolate Roll With Cream • Barbecued Beef Patties Field Peas and Snaps Apple and Grapefruit Salad Peach Tapioca	**27** Orange Halves Toast, Preserves • Spanish Steak Creamed Potatoes Green Beans Blackberry Cobbler • Creamed Chicken on Egg Noodles Lima Beans Pear and Cheese Salad Lemon Custard	**28** Fried Apples Ham and Grits • Smothered Chicken Rice With Gravy Steamed Spinach Spiced Peaches Cherry Ice Cream • Link Sausages Baked Apples Green Peas Sliced Tomatoes Butterscotch Pudding		

Ready-to-eat or cooked cereals are offered on all breakfast menus.

Moisture Problems and Control

GEORGE BLUMENAUER
Architect
Hospital Consultant
Little Rock, Ark.

A FUNCTION of buildings is to prevent wind, rain, snow, excessive heat, cold and sunshine from coming in where and when they are not wanted and thus interfering with the living or working conditions and comfort of the occupants. Primarily, it is to control these conditions that buildings have walls, roofs, windows and doors.

Irrespective of kinds of material or methods of construction, the elements are ever at work; moisture, wind and thermal variations strive persistently to enter a structure where any means of entrance may exist or occur, and time and the elements are the principal destroyers of buildings.

PLANNING IS BEST PRECAUTION

Owners, planners and builders who give serious thought to problems of maintenance, depreciation and obsolescence will use every reasonable precaution in the planning and construction phases of a project to safeguard vital areas into which the elements, especially undesired moisture, may penetrate. There is no precaution that will equal proper planning and supervision of the construction and proper materials and construction methods. The owner who insists on certain economies—and sacrifices certain safeguards to obtain them—may learn from later experience some of the difficulty and expense involved if it becomes necessary to remedy defects in structures after they are built.

Condensation. Moisture accumulation, commonly called "condensation," is often encountered in buildings, many of which show evidence of this phenomenon. It occurs on the first available surface that is cold enough to be below the dew point of the air.

Where temperatures are cooled below the dew point in enclosed space, condensation may be expected, and condensation troubles increase as relative humidity increases. Condensation of moisture may cause serious damage in a building over a period of time, such as decay, corrosion, deterioration of plastering, damage to painted surfaces, and damage to building contents.

In addition to natural moisture in the atmosphere, there is the problem of vapor produced inside the building from steam, unvented gas-burning apparatus, and vapor wastes from human beings or animals.

Modern windows and doors tend to prevent air leakage, thus lessening the natural tendency of inside and outside air to equalize normally. Ventilation lessens the probability of condensation. Where moisture accumulates on ceilings, such as on the underside of a monolithic flat roof slab which forms the ceiling of the room or space below, the condition can be helped by opening one or more windows a crack at the top. Such roof slabs, especially in cold climates, should be heavily insulated against thermal variation.

In some types of construction, vapor barriers help to keep atmospheric moisture from entering buildings. Lack of attic ventilation during cold weather may contribute to cooling a ceiling surface directly beneath to a temperature below the dew point. Where the interiors of buildings are ventilated by positive means at night the danger of moisture condensation will be lessened.

Cold water pipes commonly provide surfaces on which moisture will condense. On horizontal runs of such piping condensation may become troublesome and cause dripping. Moisture of this nature can be absorbed by wrapping the pipe with a proper kind of felt or like insulating material and the insulation usually is best applied when the work is in the construction stage.

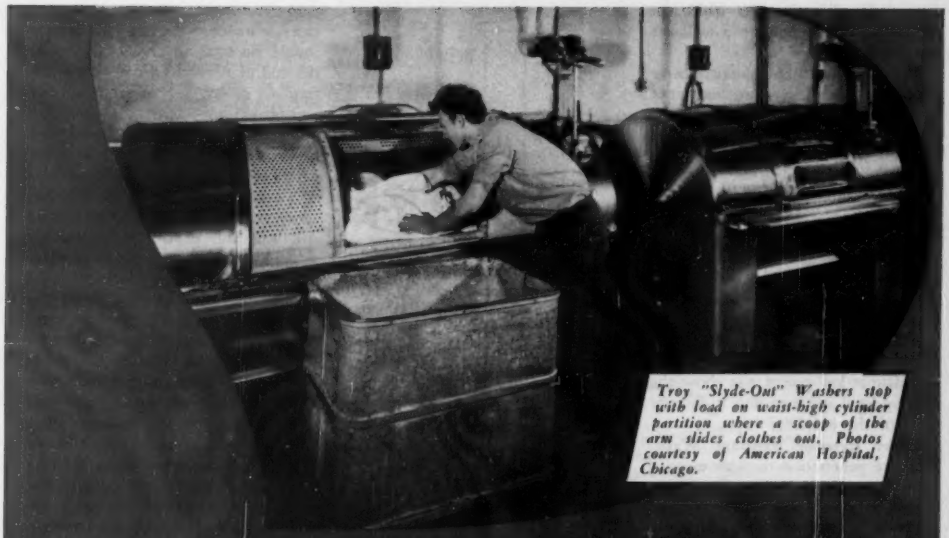
Roofing and Flashing. A common source of moisture infiltration into buildings is through the roofing or as a result of flashings which are so constructed as to provide moisture-conductive paths.

Modern roofing materials that conform to federal specifications or to the A.S.T.M. standards—and are otherwise undamaged—usually are of uniformly good quality. In installing the materials in the construction the factors to be considered are the workmanship and the base over which roofing is applied.

MANUFACTURERS GIVE BOND

When a question exists in the owner's mind regarding the roofing, the instructions provided by the manufacturer for installation of his material will merit study; they are readily obtainable on request. Specifications provided by the manufacturer generally will show and describe the satisfactory ways in which the roof and flashings should be applied. In order to guard against defective installation it is usual for the contractor to provide the owner with a surety bond, effective during a period of 20 to 25 years, to guarantee the performance of his work and materials.

Standard forms of surety bond for roofing will cover materials, workmanship and flashings. The architect and specification writer should know how to detail and explain the roofing contract requirements; but owners some-



Troy "Slyde-Out" Washers stop with load on waist-high cylinder partition where a scoop of the arm slides clothes out. Photos courtesy of American Hospital, Chicago.

Another hospital installs

TROY "Slyde-Out" WASHERS

for speed and convenience at lower cost

Troy 40" Atlas Extractor in same laundry. Features include patented "Center-Slung" suspension, automatic brake and timer.

Another view American Hospital laundry, showing Troy 2-roll return-type Flatwork Ironer. Two Troy Minute-Man Tumblers in background.

The minute you step into the laundry of American Hospital in Chicago, you notice the smart, streamlined appearance of Troy "Slyde-Out" Washers. Here is today's modern, practical solution to hospital washing problems.

The efficient washing action of Troy "Slyde-Out" assures that your linens are always snowy-clean. Patients, visitors and your staff are favorably impressed . . . your institution's reputation is enhanced. Easy "Slyde-Out" operation — minus the customary backbreaking unloading labor — is a welcome relief for laundry employees. And for you, Troy "Slyde-Out" Washers mean reduced labor and maintenance costs.

Follow the lead of so many modern hospitals that have installed Troy "Slyde-Out" Washers. Write today for free catalogue on "Slyde-Out" Washers and complete line of Troy equipment.

TROY LAUNDRY MACHINERY

DIVISION OF AMERICAN MACHINE AND METALS, INC.
EAST MOLINE, ILLINOIS

times insist on economies which, in the planner's view, may tend to lower the safety factor.

Flashings should be of noncorrosive materials. Metal flashings should not extend less than 4 inches into the masonry. There will be parts of a building where "through wall" flashings are most serviceable. On flat roofs the flashings generally should not be less than 10 inches high, which under any anticipated condition will allow a water accumulation on the roof without threat of overflow at the flashing level.

A frequent source of flashing trouble at parapets conjunctive with sloping roofs is that water may accumulate at low points, rise above the flashing level and then flow to interior parts of the building.

Leaky Exterior Masonry Walls. Moisture penetration through exterior masonry walls is almost invariably caused by poor workmanship or poor methods of construction. Moisture from wind-driven rain and snow has great penetrating qualities and the areas where moisture from this source appears on the interior surfaces of walls or other construction may be a considerable distance from the exterior point of entrance. Mortar joints tend to be the "Achilles heel" in masonry wall construction and careless laying of masonry units in a wall in this respect is all too prevalent. This weak point can be kept under reasonable control by enforcing proper specifications and by thorough supervision and inspection as the masonry work proceeds.

"SPEED METHOD" HAZARDOUS

Two moisture hazards are created by the modern tendency to erect thin walls and the "speed method" of laying masonry units in the wall. In this method of laying, the head joints and bed joints invariably are not fully filled with flat beds of mortar. Experience shows that small openings thus are left in the mortar joints through which water can enter and small reservoirs are created where it can accumulate and thus seep into the building.

Too often, it seems, owners will ask: "How many bricks will the masons lay per day on our job?" rather than, "How can we be assured that the exterior masonry walls will not admit moisture into the building?" There may be a definite relationship between these two questions. Where it is intended to paint or otherwise

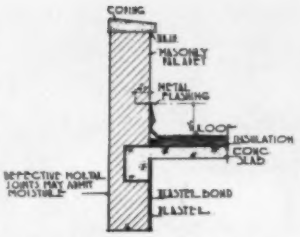


Fig. 1. This drawing shows a durable method of roof flashing set in a masonry wall. Under some conditions the flashing can be improved by extending it all the way through the wall.

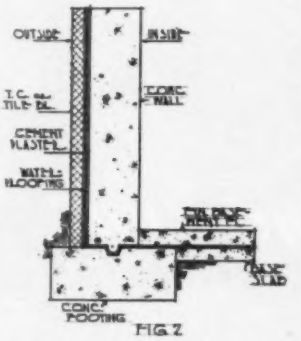


Fig. 2. This indicates an effective method of dampproofing a basement wall and floor where the soil would carry a heavy volume of water under very severe conditions of moisture.

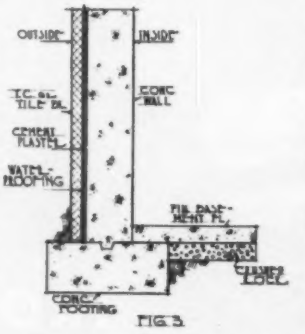


Fig. 3. A satisfactory method of dampproofing a basement wall and floor under ordinary conditions of moisture.

treat or decorate interior surfaces of exterior masonry walls, particular care should be used in erecting them to the end of preventing moisture penetration. Even a small amount of penetration to interior surfaces may cause damage and deterioration and be unsightly; eventually it may cause deterioration of the structure.

Where the interiors of exterior masonry walls are to be plastered, furring the wall will provide an additional safety factor against moisture penetration. The correct type of plaster bond applied over the masonry before the plaster is applied will tend to effect a break in continuity of moisture-conductive paths. Furring the inside surface of exterior masonry walls with hollow building tile or an equivalent material is another precaution. But merely to fur a masonry wall inside with hollow tile or equivalent material or to use a hollow tile back-up for brick or stone masonry facing is not always an assurance against moisture penetration.

ADVANTAGES OF INSULATION

Where winter is severe and a relatively long heating season is required, two advantages will result from insulating the exterior masonry walls. Insulating material, 1 inch or more thick depending upon the requirements and kind of insulation, can be applied on the inside surface of exterior masonry walls on an asphalt emulsion adhesive. The adhesive also serves to form a break in moisture-conductive paths in the masonry.

In cold climates the heat loss through uninsulated masonry exterior walls is a substantial item, owing to the natural tendency of temperature to equalize so far as possible; the likelihood of condensation on the insulated wall is less than it is on an uninsulated wall.

The preliminary economic setup for the project can help to show whether or not an investment in insulation will pay dividends on the additional capital required to install it.

Insulating the exterior walls will effect a saving in the amount of heating equipment required for the original installation, as compared with equipment that would be required where masonry walls are uninsulated. The saving would accrue from the smaller boiler capacity required, saving in radiation, and possible reduction in the size of piping. During the years of operation the saving in heat

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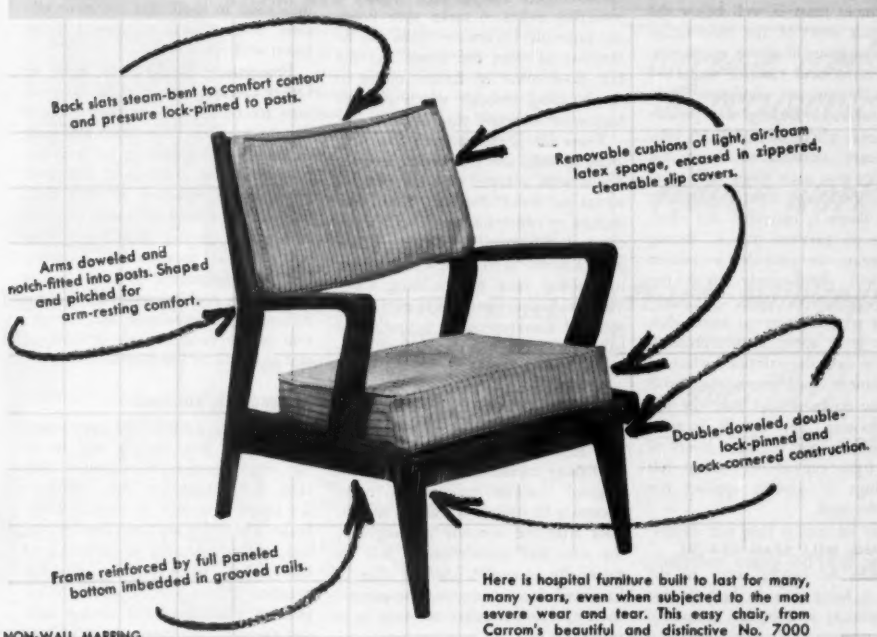

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loss, resulting in fuel saving, should pay dividends on the amount of capital invested in wall insulating. This dividend rate would be substantial in a properly managed hospital.

Windows, doors and other openings framed in exterior walls commonly provide means for water to enter a building. Usually this condition can be met satisfactorily by sealing the space between frame and masonry with calking compound applied under pressure.

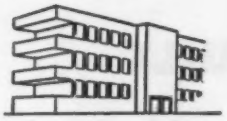
Dampness in Basements. Usually the basement mass is well below the finish grade level of the building so that moisture is likely to appear on interior surfaces of exterior walls and floors or as moisture condensed from the atmosphere. During wet periods and in areas where the soil holds relatively heavy amounts of water, the probability that such water will penetrate into buildings through basement walls or floors is increased. An effective way to prevent this is, during construction, to provide a barrier which will permanently break the moisture-conductive path. Probably the most effective way to accomplish this aim is to apply a waterproofing membrane over the exterior surface of the basement wall, from the finish grade line down to and over the top of the footing. This usually is done by embedding one or more layers of burlap, light canvas or roofing felt in coatings of asphalt applied hot against the wall.

MEMBRANE WILL SPAN CRACKS

If cracks or checks occur in the wall it is fairly safe to believe that the membrane will bridge them. An integral waterproofing compound can be added to the concrete mix as a precautionary measure; however, its effectiveness will be lessened if checks or cracks occur in the wall.

It also is practical to provide a moisture-conductive path adjacent to the exterior surface of the wall to prevent the accumulation of water-logged soil against the wall following heavy precipitation. A like condition would prevail in the case of basement floors.

Moisture problems in excavations for basements and shafts may be increased where water under pressure is encountered—by no means an infrequent occurrence. In some sections of the country this condition may be anticipated. In such areas the engineering problems should be solved as the local situation can be evaluated.



There are instances where water may back up into a fixture or floor drain from a sewer line and cause inconvenience and damage. Where a condition exists to make such flooding probable, back-water traps can be installed between the sewer and the first floor drain or fixture outlet in the building through which possible back-water overflow may occur.

There also is the question of sealing areaway walls and connecting areaway drains with a sewer or other positive means of water disposal. Roof conductors or other means of roof water disposal should not deposit their flow in such a way as to cause a soggy place to develop near the building walls. This condition sometimes causes settlement of foundations or saturation of basement walls and consequent damage to the structure.

It will be noted from the foregoing that the best basic solution to the problem of preventing water infiltration through walls and floors lies in preventive measures taken during the original construction. When it is necessary to correct a leaking wall or floor after the structure is completed, the cost and inconvenience will be materially increased. In the case of basement floors corrective measures—short of a new installation—may be in vain.

The problem of controlling atmospheric moisture in basements lies primarily in lessening, so far as practicable, the moisture content of this air, including such vapors as are produced within the structure, plus sufficient ventilation.

Leaky Plumbing and Heating Pipes. Maintenance and obsolescence problems should be anticipated where mechanical equipment is installed in a structure. The accessibility of piping will be a factor in making routine inspections and in the ease and cost of making repairs. Plans for long-term economy are enhanced when conductors (piping) for liquids or vapors are as corrosion-resistive as possible. Corrosion holds at least two disadvantages: eventually it may cause perforations in the piping, and the process of corrosion will tend to decrease the pipe area and thus lessen its capacity. In the long-term view it seems unwise to economize by installing unsuitable kinds of pipe and thus encourage corrosion.

Hospitals, with their necessarily extensive amounts of costly mechanical equipment, merit careful study while the project is still in the planning stage. The mere fact that a mechanical engineer may have done the engineering on 50 hospitals is no indication in itself that the most efficient, practical and economical installation will result.

Promenade Deck Over Roof or Other Decking. Roof areas are often used for other purposes than to keep out the weather. It is often necessary to lay a wearing surface for walking, play areas, sun bathing or like purposes over a flat roof. In such cases precautions should be taken (1) to protect the roofing membrane from harm, and (2) to allow for a tendency of roofing membrane to adhere to the promenade decking material and for differences in expansion and contraction of the various kinds of material that are used in conjunction.

ADHERES TO ROOFING

A wearing surface laid over promenade deck areas usually will be of tile, thin concrete slabs, or a thin layer of flat flagstones. These materials are likely to adhere to roofing membrane where the surfaces come in contact, owing primarily to softening of the asphalt in roofing during hot weather. In the normal process of expansion and contraction during varying thermal conditions there will be a tendency for promenade decking to force the roofing membrane to move, which may cause breaks in the membrane and, eventually, leaks.

Each kind of material should be allowed to contract and expand irrespective of the other. This can be accomplished by placing a nonadhering, decay and corrosion resistive covering over the roofing membrane between the decking and membrane, which thus may expand or contract without adversely affecting the roofing membrane.

Where promenade decking is installed over roof areas at intersection with parapet walls, the flashing should be so placed that it cannot be damaged by persons using the promenade decks.

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MRS. HERTHA P. McCULLY
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TIMING is probably the most important factor to be considered in taking a linen inventory. All flow of linen must be stopped for a given time in order to ensure an accurate count, and inasmuch as linen plays such an important part in the care and comfort of the patient it must be released for use as promptly as possible.

The system of taking inventory which I devised at the 400 bed George Washington University Hospital, Washington, D.C., enabled us to make a complete count of the linen in just one hour. The technic required a good many hours of planning and the cooperation of all departments involved. In order to facilitate the counting, a conference of department heads was held at which we made plans to cover all problems that might be encountered.

COUNT STARTED AT 2:30

The stage was set to begin the count at 2:30 p.m. two days later. The head nurse on each station was instructed to have one nurse available for each station to enter each room to make the actual count piece by piece, followed by the linen closet count of clean linen, and also whatever soiled linen might have accumulated in the utility room.

This nurse was to be accompanied by a completely disinterested person recruited from one of the various clerical departments of the hospital. The duty of the clerical employe was to call off items on a specially prepared inventory form and enter the amounts counted by the nurse. These inventory forms were made up to include all items used in patient areas, the headings of which were entered horizontally across the page. Room numbers were entered vertically on the left margin of the page.

Identical forms could be used on patient floors, but special forms were prepared for such departments as operating rooms, delivery rooms and central supply which included the various types of linen used in these departments. A test count was made on a typical floor the day preceding the actual count. Since we recruited employes from other departments we felt it desirable to be able to guarantee that we would use them for a given length of time only, thus assuring cooperation for future inventories.

On the day of the inventory signs were made indicating that the linen chutes would be sealed at 2:30 p.m. and would be unsealed at 3:30 p.m. These signs were sealed on the chutes promptly at the designated time. Clerical assistants reported at the housekeeping office to pick up inventory forms, pencils and instructions; they then proceeded to their assigned stations, and the count was begun. The assistants called out the items and the nurse made the count, not only on beds but also in closets, dresser drawers, and any other hiding places. The hospital was divided into 21 approximately equal sections, for the purpose of completing the count in one hour.

While the count was in progress, there were other gaps to be closed. The linen room was closed and the count was made with an adequate staff of persons familiar with all types of linen. A similar group counted the reserve stock. Seamstresses counted the linen to be mended in the sewing room. The laundry had arranged for a staggered crew to work until all the linen in the laundry at 2:30 (when chutes were sealed) had been processed and counted.

Soiled linen could have been counted in the laundry at this time, but the other arrangement was used in the belief that clean linen is much more easily and carefully counted than is soiled linen. When the chutes were sealed all soiled linen was removed from the sorting room and placed in baskets for processing. Laundry workers remained at their posts and finished this linen, and an accurate count could then be made. After the chutes were opened at 3:30, any linen that accumulated was kept in the sorting room because it had already been counted on the floors. None of this linen was processed until the following day. Windows between laundry and linen room were not opened for passage of clean linen until the laundry count was completed. During the time the count was being made, I circulated about floors and departments to answer questions or clarify any instructions.

COMPLETED AT 3:30

By 3:30 p.m. every station and department had turned in to the housekeeping office its completed assignments, with the exception of the laundry. However, by the time totals had been run on the adding machine and entered on final inventory sheets the laundry count was completed, an accurate count of all linen in the entire hospital had been made and tabulated, and copies were ready for distribution to the administrator and other departments involved.

The actual linen count was accomplished in one hour; taking totals and typing the final inventory sheets required one and one-half hours. Complete time involved was two and one-half hours.

Inasmuch as the hospital had been open for only a little more than a year at the time the inventory was taken, it was simple to determine how much linen had been in use during that period. The discrepancies brought to light by the inventory were revealing enough to make us aware that we must take further steps to tighten our linen control.

DR. WILINSKY—

(*Continued From Page 44.*)

poses," the city fathers decided, not without a certain amount of help from Wilinsky, to establish a citywide system of health centers on the Blossom Street plan. This was done, and Wilinsky has been running the system ever since. "We provide everything," he said not long ago, describing the operation of the health centers to an acquaintance. "For example, our prenatal and infant care clinics have reduced the city's infant mortality rate from 100 to 30 per thousand live births—and we look after half the new babies born in Boston! We also have dental clinics, visiting nurse service, tuberculosis case-finding, and all the other usual health department functions. But the most important thing we have done is to link welfare and health services together. We never lose sight of the relationship between poverty and disease."

For many years, Wilinsky has been preaching what he practices. In a symposium on public health at a district medical society meeting twenty years ago, he emphasized the importance of social and economic factors in community health. "In order to obtain satisfactory results it is necessary to bring together physically, whenever possible, the agencies in these fields," he declared on that occasion. "This has been accomplished through the development of our health units. The invisible line between poverty and disease more than justifies the intimate alliance within these buildings."

TRADITIONALISTS WERE SUSPICIOUS

Sentiments like these were hailed as gospel by city officials, welfare workers and their clients, but they aroused suspicion tinged with anxiety among medical traditionalists, a group which then, as now, included the majority of practicing physicians. "Several unfortunate episodes have irritated the medical men of my vicinity and have made them suspect the Health Department of acute inflammatory aggressiveness," one practitioner said in a reply to Wilinsky at the district symposium. Explaining that the episodes were attributable to "overvigorous proselytizers" among public health nurses who were "just learning the technic of home invasion," and acknowledging that Wilinsky's own motives were unquestionably above reproach, the practitioner nevertheless made it explicitly clear that the doctors had their guard up. "Most practitioners distrust the tendencies of many of our restless pioneers who are experimenting fully as much in the province of sociology and economics as they are in their legitimate fields of medicine," he concluded. "They think that some of our medical leaders classify the practitioner as a preventable disease. Dr. Wilinsky's energy, initiative and ability have procured for him such a national reputation that he may be called away. A new Alexander, with less judgment but with plenty of energy, might want to plunge ahead more recklessly along paternalistic lines."

The doctor may have been right, but the new Alexander never appeared to prove it. Instead, the old Alexander has kept on plunging ahead, his soft-spoken diplomacy and general benignity of purpose offsetting the fact that the direction has been consistently toward medical paternalism. Since Blossom Street days, moreover, something new has been added to Wilinsky's concept—the hospital. "The hospital is in a very advantageous position to conduct a public health program in cooperation with existing health agencies, and to function as the health center of the area it serves," he said at an American Hospital Association convention in 1936, exactly 10 years before the national Commission on Hospital Care said the same thing following a two-year study of hospital facilities in the United States. After hearing Wilinsky's report as chairman of the A.H.A. committee on public health relations at the 1936 meeting, Dr. D. L. Richardson of Providence, R.I., who was presiding at the time, said prophetically that the significance of Wilinsky's recommendations would be fully realized "within a period of ten or fifteen years."

As Wilinsky takes over the American Hospital Association presidency for 1951, still preaching the doctrine of integrated service, Dr. Richardson's time-table may turn out to have been only slightly optimistic. Like the doctors who feared "home invasion" by health departments twenty years ago, however, there are some today who fear "encroachment" by hospitals on the practice of medicine. Privately, Wilinsky has no patience with the militant medical groups which scream "Corporate Practice!" at hospitals employing a few specialists on salaries, and on at least one occasion he has referred to the tactics of these groups, which have tried to keep their members from accepting salaried hospital appointments, as "economic blackjacking." Publicly, however, he will avoid a fight if possible, just as he always avoided fighting with district practitioners in Boston—not only because he usually gets his way without bloodshed but also because he is essentially a peace-loving soul who abhors conflict and wants to be friends with everybody.

As a matter of fact, the nation's hospitals already owe a lot to Wilinsky's talent for friendship. On a number of occasions when things have looked black for hospitals in Washington, a well placed word from Wilinsky has saved the day. This hasn't been necessary so much in recent years, since the American Hospital Association has had an ably staffed Washington office, but during the early days of World War II he was called on more than once to pull the bedpan out of the fire. This was almost literally the case, for example, when the War Production Board was about to put a restraining order on the production of bedpan flusher-sterilizers, and Washington brass was deaf to the profession's plea that the sterilizers were essential labor-saving devices in an essential industry. When the axe was about to fall, Wilinsky put through a call to the White House, where he was on a first-name basis with, among others, Presidential Advisers Harry Hopkins, Tom Corcoran, Ben Cohen and David Niles. The order was never issued.

EXERTS CONSIDERABLE INFLUENCE

Wilinsky is also on intimate terms with numerous senators and congressmen, relationships which he doesn't hesitate to use when a public health or hospital issue is at stake. Insiders give his influence a share of the credit for passage of the Hill-Burton Act, which is building a billion dollars' worth of hospitals in the U.S., and there is no question that his political finesse has helped point the way out of many a legislative muddle involving hospitals.

If he is among friends in Washington, however, Wilinsky is a real public character in Boston, where he glitters like the Statehouse dome. "If you want to talk to Charlie privately you might call him up, or meet him in the concourse of South Station," a

friend complained not long ago. "Whatever you do, don't go to lunch with him at the Copley-Plaza. It's like eating with Jack Dempsey at Jack Dempsey's—everybody in the place wants to shake hands and say hello." Unlike Dempsey, Wilinsky is short and stocky, with sparse, neatly combed white hair and pale blue eyes. He dresses nattily but conservatively in dark blue or gray pin-stripes, usually with a figured tie, and, occasionally, a boutonnière. Greeting friends in the dining room of the Copley or the Statler in Boston, Wilinsky looks more like a successful merchant or stockbroker than a crusading physician.

In contrast to many public figures in and out of the hospital field, Wilinsky is not a man who is friendly with the wheels but ignores the spokes. An administrative colleague who recently went through Beth Israel with him observed that he had a smile and a kind word for every employe they met during their tour. "The people at the hospital like Charlie, too," the friend said. "You can always tell," he added, noting a phenomenon that is well known among hospital administrators, who like to spend their vacations tramping the corridors of hospitals away from home. These excursions are not without hazard to the host administrator's reputation and professional pride. Walking around Wilinsky's hospital with him one day, an administrator on a casual visit opened a door to reveal a litter of rubbish on a little-used back stairway. This was during the war, when hospitals were desperately short of help, but Wilinsky didn't offer any of the excuses or explanations that might have been justified under the circumstances. "I am humiliated," he said simply, closing the door and turning away.

Wilinsky is frequently as dramatic but not always as humble as he was on that occasion. At times, he can deliver the most outrageous clichés with an air of pontifical solemnity that would do credit to a major prophet. At one recent meeting he referred during a single twenty minute speech to "those who labor in the vineyard of health," "the movement so close to our hearts," "the Biblical threescore years and ten," "an aroused, well informed citizenry," and "the political clouds affecting the public health." Wilinsky concluded this talk by gazing reflectively at the past and looking optimistically to the future. He got a tremendous ovation.

As he faces a year on the hospital banquet circuit, the new president has one terrific physical advantage over most of his predecessors. He is hard of hearing, and any time he wants to he can turn the switch on his hearing aid and shut off the relentless flow of introductions, reports, predictions, appreciations and discussions in which the average association president is helplessly engulfed. The chances are, however, that Wilinsky will do nothing of the kind. Instead, he will pay more attention to all this talk than most men with normal hearing would. He will stay tuned in to hospital discussions, because his interest in health and hospitals is unflagging and his devotion to the people who share this interest is bottomless.

Listening to the reports that are made at the hospital meetings he attends this year, Wilinsky will have the deep satisfaction of knowing that his life-long dreams of an integrated health service are closer to fruition than they have ever been before. Like Jacob, who wrestled with an angel and was called Israel, "He hath power with men, and he hath prevailed."

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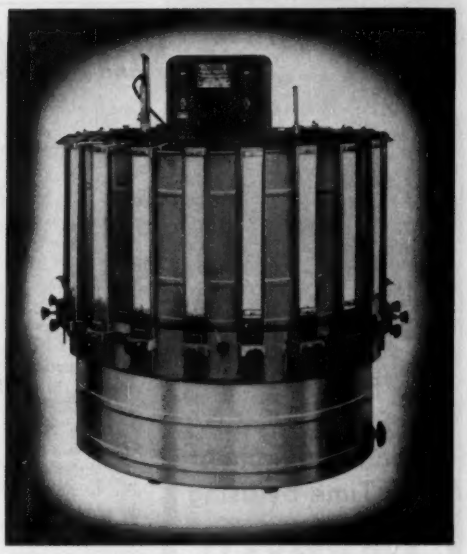

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(*Continued From Page* 80.)

1945) the trend has been away from the falling line of real wages. This trend reflects essentially the extraordinary rise in per diem charges and is prevented from attaining greater heights only by the *fall* in average length of stay. Despite achievements of medical science in reducing the length of stay, the rising costs of hospital operation have resulted in increasing charges to patients. However, consumer purchasing power has, since the war, been steadily falling. Thus the patient in 1948 found it more difficult to pay for hospitalization than he did in 1944, and is in about the same position as he was in 1939.

Factors affecting length of stay. If hospital occupancy rates fall from their wartime peaks, tendencies toward longer stays and higher rates would result in even larger total charges to patients. Some hint of this is found in the rise in length of stay for deliveries (graph 3). Actually, high employment levels and high effective medical purchasing power are vital for the maintenance of hospital occupancy rates. Full employment and high wages would also favor the wider extension of medical care insurance, another guarantee of optimum utilization of and payment for hospital services. The fall in real wage rates and employment in recent months does not, however, justify optimism in this regard.

LENGTH OF STAY REDUCED

The central rôle of length of stay in determining charges to patients requires that careful attention be given to any measure designed to prevent or shorten hospitalization. In this connection, adequate diagnostic and treatment services for ambulatory patients and home care programs for the convalescent and chronically ill would reduce the length of the hospital stay. Patient, hospital and insurer would benefit through the provision of better outpatient service and proper aftercare arrangements. It would seem, then, that a solution for the problem of rising hospital costs depends upon not only the general economic well being of the country, but also the broadening of the scope of service in organized medical care plans.

Suggestions for hospital record systems. Experience in the conduct of this study suggests the need for some uniform system of patient identification, similar to the "charge-a-plate" system of department stores, so that every index card, clinical record folder and ledger sheet applicable to a particular patient would carry the identical impress of name, address, age, sex, and so on. Such impressed records could be supplied to all personnel soon enough after the patient's admission to obviate individual preparation of forms. This would free professional personnel for more appropriate work and would facilitate clinical and administrative research. A "once and for all" determination of patient-identifying information should result in more nearly accurate filing and processing of these records. Year-to-year uniformity of forms might well encourage research in long-term trends.

As a necessary corollary of this procedure, standard policy should be determined as to the precise conventions that apply to the gathering and recording of identifying information. The centering of this responsibility in one or possibly two trained individuals might have advantages over the present tendency to disperse this function among physicians, supervising nurses, medical record librarians and accounting personnel.

Inherent in hospital operation is the "dead records" problem. No panacea is possible for all situations, but the following questions are involved. What is the need for and value of storage space as against functional space? How often are such dead records needed and used? What is the cost of microfilming or off-premise storage as compared with extra record space construction?

References

[1]Consumers' Price Index for San Francisco, California, Bureau of Labor Statistics, United States Department of Labor, San Francisco, 1939-1948.

[2]Gross Average Weekly Earnings, Production Workers in Manufacturing Industries, Five Bay Area Counties (Alameda, Contra Costa, Marin, San Mateo, and San Francisco), California State Department of Industrial Relations, San Francisco, 1939-1948.

Acknowledgments

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View of the new central wing of Bronson Hospital, third unit of the expansion program, under construction, during the early stages of the campaign.

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In 1946 when the Bronson Methodist Hospital at Kalamazoo, Michigan, decided on a community-wide campaign for funds to expand hospital facilities, Ketchum, Inc. was called upon for experienced professional direction. An over-subscribed sum of $1,079,097 was raised. The staff representatives of Ketchum, Inc. left behind them in Kalamazoo, "a legacy of good-will," in the words of Hospital Superintendent W. C. Perdew.

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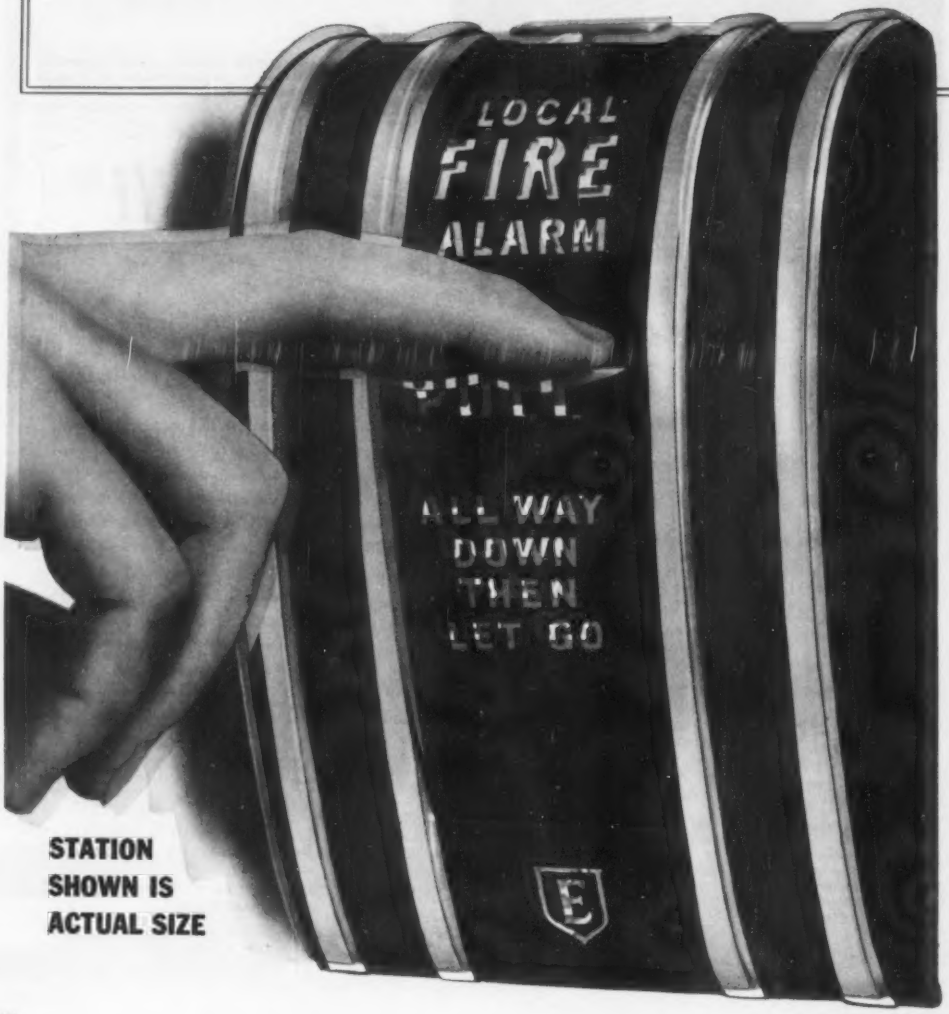


STATION SHOWN IS ACTUAL SIZE

NEWS DIGEST

Hospitals to Be Affected by Controls . . . Patients Moved to Safety in Miami Valley Fire . . . Maintenance Workers Strike . . . Northwestern Seeks $250,000 Fund . . . Oklahoma, Florida, Illinois, Missouri Meetings

Hospitals to Be Affected by Manpower Shortage, Controls on Essential Materials

WASHINGTON, D.C. — Hospitals can look forward to increasingly severe shortages of professional and technical personnel and growing difficulty in obtaining supplies under controlled materials plans foreseen by government officials, it developed from statements released by various agencies here last month.

On the basis of information available in mid-December, however, it appeared unlikely that there would be food shortages or that food rationing would become necessary.

A report prepared by the Labor Department's bureau of labor statistics named the health professions as one of eight occupational fields in which shortages of qualified personnel can be expected to develop. In a general "tightening up of the labor market" resulting from the national mobilization program, health workers have emerged as one of the groups for which "urgent demands" have been created, the bureau reported.

The fact that there had been a relatively small number of unemployed before the national defense program got under way was cited by H. B. McCoy, assistant administrator of the National Production Authority, as one reason the present emergency is likely to upset the national economy more than expansion of military demands did in the early days of World War II.

"We find ourselves with an urgent necessity to greatly expand production for national defense and at the same time having an economy that is operating at almost maximum levels for non-defense purposes," Mr. McCoy said. "We do not have a large number of unemployed to be absorbed in new production. It is obvious that the imposition of a large defense production program on an industrial system already operating at peak levels would result in an immediate, and in some cases somewhat severe, dislocation to ordinary industrial production and distribution of goods."

Mr. McCoy explained that N.P.A. regulations were aimed at assuring so far as possible that essential materials would be available for military production with the minimum "adverse impact" on other industrial production and distribution of goods. He acknowledged that some hardship on nonmilitary industries would inevitably result from these controls. "We are making adjustments for hardship cases and making every reasonable effort, within the limits of supply of materials, to prevent any consumer from suffering losses in operation," he declared.

The voluntary price freeze called for on December 19 by Economic Stabilization Director Alan Valentine was not generally expected to succeed in stemming inflationary trends, and many Washington observers were looking for further regulatory edicts soon after the holiday season, if not earlier.

One official, N.P.A. counsel Manly Fleischmann, looked for a full controlled materials plan to be in operation by midyear. As envisioned by Mr. Fleischmann, the program would first involve control of metals under a plan which would allocate supplies only to industries considered essential in a war eco-

(*Continued on Page* 138.)

Patients Moved to Safety in Miami Valley Hospital Fire

DAYTON.—Seventy-five patients including 35 babies in the newborn and pediatric department nursery were safely evacuated when fire broke out in the old administration building of the Miami Valley Hospital here at 6 p.m., December 16.

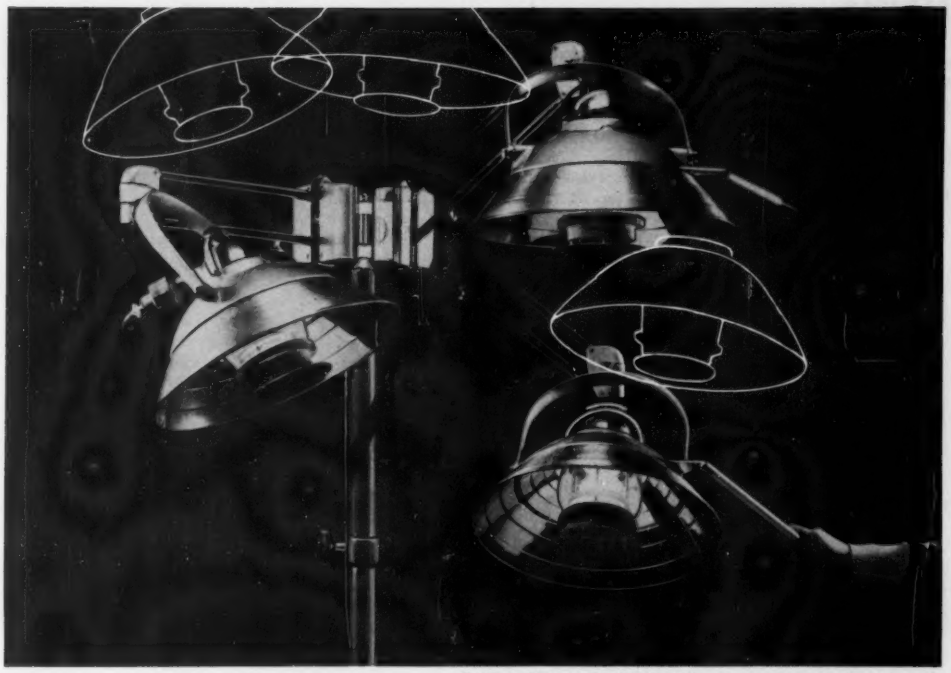
Cause of the fire was determined to be a burning cigaret that had been carelessly thrown into a stairwell between the first and second floors of the hospital building.

The building is of nonfireproof construction but was protected by a sprinkler system and fire doors which operated effectively to prevent spread of the fire, Dr. Frank Sutton, administrator, reported. The building normally houses approximately 200 patients, he said.

Patients evacuated when the fire was reported were in the obstetrics and pediatrics departments of the hospital, grouped around the stairwell in the center portion of the building. Other patients located in extreme parts of the building were not disturbed.

The hospital had a carefully worked out evacuation plan which operated smoothly in the emergency, Dr. Sutton explained. The plan had been developed with the aid of local fire department personnel. In the event of fire, hospital employes were to concentrate on the evacuation of patients, leaving fire department personnel free for specific fire-fighting duties. Following the fire on December 16, fire department officials praised the prompt action of employes in following out the prepared plan and evacuating patients from the endangered area. This action made it possible for firemen to start combating the fire immediately after they arrived. If patients had not been evacuated promptly, the fire department might have been handicapped, with resulting further property damage and possible loss of life, a fire department spokesman said.

Damage caused by the fire was estimated at $50,000, Dr. Sutton reported.



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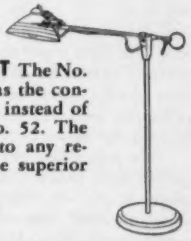

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NEWS...

J. P. Cox Named President of Oklahoma Association at 31st Annual Meeting

CHICAGO.—The Oklahoma State Hospital Association held its 31st annual convention at Oklahoma City November 16 and 17. With a registration of 385, it was the best attended meeting in the history of the association.

The following officers were elected: president, J. P. Cox, Oklahoma Baptist Hospital, Muskogee; president-elect, Harry Smith, Wesley Hospital, Oklahoma City; vice president, Celeste Kemler, Valley View Hospital, Ada; treasurer, Sister Mary Fidelise, Blackwell General Hospital, Blackwell; trustees, Bryce Twitty, Hillcrest Memorial Hospital, Tulsa, and Sister Mary Agnes, St. Anthony's Hospital, Oklahoma City.

NEED UNIFORM COSTS

Robert Penn, specialist in hospital accounting, opened the convention with a discussion on methods of fixing hospital charges. Mr. Penn stressed the efforts of Blue Cross groups, the American Hospital Association, government agencies, and others to get hospitals to adopt a standard chart of accounts and from this standard chart to work up standard and comparable cost reports. "Cost analysis, with profit and loss statements from the income producing departments will assist in intelligent rate setting," Mr. Penn stated. He suggested that the usual day rate charge be broken down into three components: (1) room, to be a separate charge; (2) meals, to be a separate charge, with amounts varying depending on whether patients have regular meals, special diets or eat nothing at all; (3) routine nursing, drugs and dressings, and miscellaneous services. Mr. Penn urged that the so-called nuisance charges be abolished and that these small charges for pills and miscellaneous drugs and dressings be combined in the regular daily service charge.

"Let's stop taxing private and semi-private room patients and hospital employes to pay for hospital care of indigent patients," Everett W. Jones, vice president of The Modern Hospital Publishing Company, Chicago, said in discussing adequate payments for indigent patients in voluntary hospitals. "Let's spread this obligation over all the taxpayers of every area." The presentation of accurate bookkeeping and cost accounting figures to all elements of society in every area would go a long way toward convincing elected officials of their responsibility to pay full cost to the hospitals for the care of indigents, he said.

Harry Smith, administrator of Wesley Hospital at Oklahoma City and president-elect of the association, urged every hospital trustee, administrator and staff doctor to sell the citizens of his area on the necessity for government payments based on the actual cost of hospital care for indigents.

Grover W. Ponton of the Hardware Mutual Insurance Company, Stevens Point, Wis., gave the following major points in developing a disaster plan: (1) There must be a well organized disaster plan committee; (2) this committee must conduct regular drills for hospital employes; (3) automatic fire detection systems, and in most areas of the hospital, automatic sprinkler systems, should be installed; (4) the hospital should arrange with the local fire department for regular inspection services. Mr. Ponton suggested that the Oklahoma Hospital Association hire a trained man on a part-time basis to help the association and its member hospitals lay out workable plans for disaster. He suggested that a retired insurance engineer might be available for such work.

Thomas Murdough, president of the Hospital Industries Association, urged hospitals not to gamble on future prices with their inventories. If all hospitals immediately start to build up their inventories, the present shortage problems will be acutely increased, Mr. Murdough said. He did urge, however, that any hospital with a building program should get its equipment and supply lists ready early in the program and get the orders placed. Mr. Murdough also pleaded for conservation and economy in the use of equipment and supplies.

N. D. Helland, executive director of the Blue Cross and Blue Shield Plan in Oklahoma, said that doctors are now talking of putting the Blue Shield plan there on a service instead of an indemnity basis.

CORRECTION

In his letter to the editors entitled "Injection Costs" which appeared on pages 6 to 10 of the December issue of The Modern Hospital, Warren W. Irwin was wrongly identified as being general purchasing agent of the University of Rochester, Rochester, Minn. The university is at Rochester, New York.

Maintenance Workers Strike at U. of C. Hospitals Over Wage Dispute

CHICAGO.—Faculty members formed a volunteer corps to shovel coal at the central power plant to keep the University of Chicago hospitals and other buildings supplied with steam when 250 maintenance workers went on strike here last month.

The striking workers were members of the A.F. of L. Building Service Employes' Union, electrical workers and other building trade unions. The hospital and other university buildings were picketed as university officials negotiated with the unions over demands for a 15 cent an hour wage increase. The university offered a 5 cent an hour increase with additional "fringe" benefits, it was reported.

The union had agreed not to picket hospital buildings in order that deliveries of supplies needed by patients would not be held up. However, it was reported that pickets did appear at Billings Hospital. Union officials said this was a mistake and the pickets were removed. Hospitals were guarded by an extra detail of Chicago police to make certain operations would be uninterrupted.

Ray Brown, superintendent of University Hospitals, said a corps of faculty members had volunteered to staff the power plant and perform other essential maintenance duties for the duration of the strike.

The strike was subsequently settled on the basis of an 8 cent an hour increase.

Heads Record Librarians

CHICAGO.—Doris E. Gleason, medical record librarian at Columbia Hospital, Milwaukee, was elected president of the American Association of Medical Record Librarians, it was reported at association headquarters here last month. Other officers named by the association were: president-elect, Marguerite Hoover, Pittsburgh; first vice president, Lillie J. Fakler, Portland, Ore.; second vice president, E. Louise Seymour, Boston; recording secretary, Frances Siffin, Covington, Ky.; treasurer, Justine M. Hanson, Minneapolis; councillors, Sister M. Servatia, St. Louis; Norma Bauman, Indianapolis; Helen McGuire, Bethesda, Md.; J. Harned Bufkin, Durham, N.C., and Inez M. Gilbert, Houston, Tex.

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NEWS...

250 Delegates Attend Illinois Hospital Meeting

SPRINGFIELD, ILL.—Erwin W. Wegge, business manager, Moline Public Hospital, was named president-elect of the Illinois Hospital Association at the annual business meeting here last month. Mr. Wegge will succeed Leslie D. Reid, Presbyterian Hospital, Chicago, who became president January 1, succeeding Leo Lyons, St. Luke's Hospital, Chicago, 1950 president.

More than 250 hospital people were registered for the two-day conference here. Topics discussed by the conference included the amended Social Security Act, hospital association activities, vocational training for auxiliary nursing personnel, trends in hospital costs, Blue Cross, and payments for hospital care of indigents.

Relations between hospitals and medical specialists were the subject of a presentation by John Storm of the American Hospital Association staff, who reviewed the background of the "Hess report" approved by the American Medical Association last June. Mr. Storm urged hospital administrators to resist pressure by specialists resulting in unsatisfactory employment arrangements. He said there is "plenty of evidence" that hospitals are not practicing medicine and that local pressure by specialist groups can often be resisted effectively through enlistment of public opinion on the hospital's side.

Administrators should familiarize themselves with court decisions in their states and should know what action has been taken in connection with specialists' contracts with other hospitals in their areas, he added. The Hess report does not necessarily reflect the opinion of the majority of the medical profession, Mr. Storm concluded.

Following a paper on hospital reimbursement for indigent patients by Eva Erickson of the Cottage Hospital at Galesburg, there was a lively discussion of technics for arriving at adequate payments. Richard Weingartner, Passavant Hospital, Chicago, said that improved public relations would make it possible for hospitals to get more adequate payments for indigent care. A number of hospital people from smaller, downstate communities denied that this was the case. "No amount of public relations can make the county or state pay money it doesn't have," was one of the views expressed in the discussion.

One delegate suggested that the only method of arriving at a satisfactory conclusion was to bring suit against the county or other government agencies involved. The general conclusion was that hospitals must work together to make people understand their problems of revenue and expense and to get proper support from the state legislature.

L. to R.: Erwin Wegge, Margaret Arnold and Russell H. Duncan talk things over at the Illinois Hospital Association meeting.

In addition to Mr. Wegge, other officers elected by the association were: first vice president, Russell H. Duncan, Carle Memorial Hospital, Urbana; second vice president, Rev. C. G. Schindler, East St. Louis; secretary-treasurer, George H. Van Dusen, East St. Louis; trustees, Orville Peterson, Aurora; Wendell H. Carlson, Chicago, and Victor S. Lindberg, Springfield.

Leslie Reid and Margaret G. Arnold, Lakeview Hospital, Danville, were named delegates to the American Hospital Association. Alternates are E. W. Wegge and George H. Van Dusen.

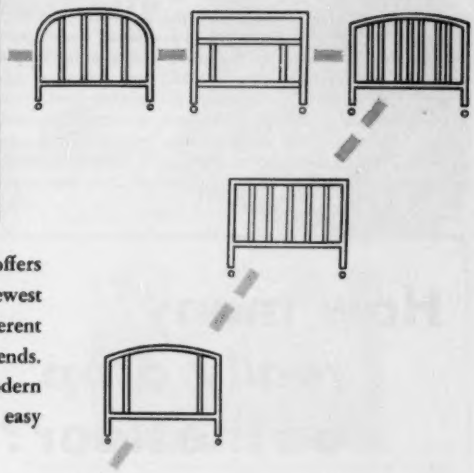
Connecticut Association Names New Officers

NEW HAVEN, CONN.—Dr. I. S. Geetter, administrator of Mount Sinai Hospital at Hartford, was elected president of the Connecticut Hospital Association at the 31st annual meeting here last month. Nearly 100 delegates attended the meeting, it was reported.

The association approved a resolution recommending that the cutback in hospital construction funds authorized under the Hill-Burton Act be restored "in order to complete hospital construction now being carried forward."

In addition to Dr. Geetter, other officers named by the association were: vice president, Edward K. Warren, Greenwich; treasurer, Philip A. Johnson, Norwich; trustees, James M. Dunlop, Bridgeport; James McK. Foley, New Haven; Chauncey P. Goss III, Waterbury; William P. Slover, Manchester, and Dr. Albert W. Snoke, New Haven.

The Means to All Ends...



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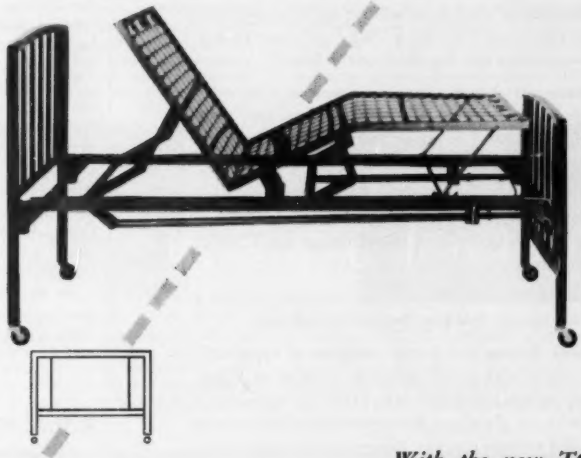

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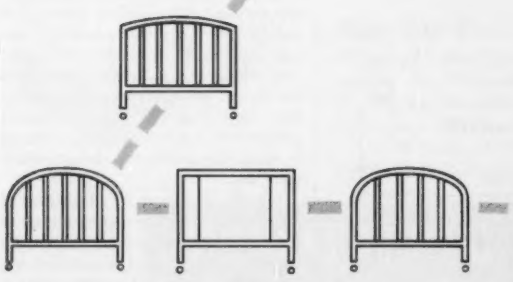

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Public Relations Problems Discussed at Session of Florida Association

ORLANDO, FLA.—Norman Losh, administrator of the Orange Memorial Hospital, became president of the Florida Hospital Association at the association's annual conference last month. Mr. Losh succeeded Dr. C. C. Hillman, director of Jackson Memorial Hospital, Miami. More than 100 delegates were registered for the two-day conference, which included sessions on social security, fire safety, hospital economies and public relations.

At a session on public relations aspects of hospital operations, several speakers developed the need for establishing better methods in the admitting office, in handling insurance cases, credit and collection procedures, accounting, nursing, food service and records—all of which were named as being important public relation aspects.

Isabelle Mustard, director of nurses at Jackson Memorial Hospital, urged administrators and trustees attending the conference to "get the nurses on the hospital planning team early and keep them on the job" for successful results in designing new facilities. Miss Mustard pointed out that only the nurse is familiar enough with detailed needs of the work area to avoid mistakes in planning.

Newly elected officers of the Florida Hospital Association talk with Dr. C. C. Hillman of Miami, the retiring president (right).

In a round table discussion on current hospital problems, an argument developed about the propriety of differential service charges for ward and private room patients. Albert Whitehall, director of the Washington Service Bureau of the American Hospital Association, said hospital charges must reflect individual costs more accurately than they have in the past in order to satisfy public demands.

In addition to Mr. Losh, other officers named by the association were: president-elect, Mother Loretta Mary, St. Joseph's Hospital, Tampa; secretary-treasurer, Mrs. Garnett L. Radin, Indian River Memorial Hospital, Vero Beach; executive secretary, H. A. Schroder, Blue Cross. Named as association trustees were: J. A. McDonald, Apalachicola, and John R. Purcell, St. Augustine.

At an annual meeting preceding the association conference, Florida Blue Cross elected C. DeWitt Miller, president.

A.H.A. Midyear Conference

CHICAGO.—The annual midyear conference of state hospital association officers will be conducted here February 9 and 10, the American Hospital Association announced last month. The association's council on association services has invited presidents and secretaries of state, provincial and regional hospital associations and local hospital councils to attend the conference, the announcement said.

Subjects scheduled for discussion at the conference include responsibilities of state hospital associations, project opportunities for hospital associations, and coordinating state and national association programs.

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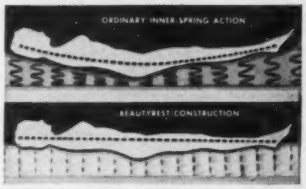

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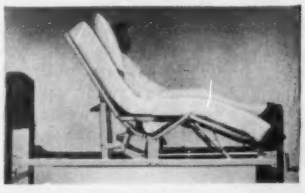

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NEWS...

Hospitals to Be Affected by Controls on Materials

(*Continued From Page* 130.)

nomy. Production of nonessential goods would be brought to a virtual standstill under this plan, it was indicated.

Controls would be established first on steel, copper and aluminum, it was suggested. If allocation of these basic materials failed to curb consumption of other strategic supplies, the government would then undertake to control all raw materials.

The timing of any such controlled materials program would depend on the rate at which the Defense Department gets under way with its own production program, it was explained.

Already, defense orders curbing consumption of nickel and aluminum had interfered seriously with normal operation of the scientific instrument and laboratory apparatus industry, representatives of the industry said last month. "The nation's instrument and apparatus companies see an end to production of at least some of their regular products within weeks, because they simply cannot procure critical materials and components under existing regulations," Aiken W. Fisher, a director of the Scientific Apparatus Makers Association, declared on December 12. Mr. Fisher foresaw that the industry might be largely converted to military production, with subsequent reconversion necessary when the importance of maintaining the supply of scientific instruments becomes apparent.

Other representatives of the industry acknowledged that machinery for investigating individual hardship cases had been established in N.P.A., but stated it would be some time before the unit would be operating effectively. Meanwhile, it was asserted, "weeks are critical to the scientific instrument and laboratory apparatus industry."

Inside all government agencies, time was being used primarily for the purpose of setting up the staffs necessary to effect price and wage stabilization, allocation of materials and manpower, and possible rationing.

Hospital Accountants Meet

ROCHESTER, N.Y.—George H. Long Jr., comptroller of Hahnemann Hospital, Philadelphia, was named president of the American Association of Hospital Accountants at the association's annual meeting here last month. Members attending the meeting discussed plans for the ninth annual institute scheduled to be held at the University of Indiana at Bloomington, July 15 to 20, 1951, Frederick C. Morgan, secretary-treasurer, reported.

Other officers named by the association were vice presidents, John M. Stagl, Chicago, and A. Fraser Moffatt, Ottawa, Ont., and secretary-treasurer, Frederick C. Morgan, Genesee Hospital, Rochester, N.Y.

$35,000 for Nurse Training

WASHINGTON, D.C.—The American Red Cross has allotted $35,000 for a program to train nursing instructors in rural areas, it was announced at national headquarters here last month. The program is planned to effect a government request that 1,000,000 persons be trained in home nursing procedures as part of the civil defense program, it was explained.

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NEWS...

Start "MacEachern Fund" to Raise $250,000 for Administration Program

CHICAGO.—Establishment of a special fund for the program in hospital administration at Northwestern University was announced here last month in connection with the university's plans for its centennial in 1951. The fund will be known as the "Malcolm T. MacEachern Fund for the Advancement of the Training of Hospital Administrators," the announcement said.

Objects of the MacEachern fund are to assure continuance of the hospital administration course and to raise a total of $250,000 in five years for expansion of the program, it was explained.

The fund was originated by alumni of the hospital administration program prior to the annual meeting of the alumni association at Atlantic City last September, the university said. At the Atlantic City meeting, alumni accepted an invitation to initiate the fund by group and individual contributions totaling $1200. By December 1, the fund had reached $2000, it was reported.

"With this fine start by its own alumni, the program is now ready to open the fund for contributions from its faculty and other individuals and organizations," Dr. Herman Smith, chairman of the fund committee, said. "The program in hospital administration is grateful for the expression of interest and support from the alumni and other friends and is confident that they will give the maximum possible help in making the hospital administration part of the centennial campaign a complete success."

Plan Celebrates Anniversary

PITTSBURGH.—The 13th anniversary of the Hospital Service Association of Pittsburgh, Blue Cross plan for western Pennsylvania, was observed here last month. Gov. James H. Duff of Pennsylvania congratulated Abraham Oseroff, Blue Cross director, on the anniversary and said that Blue Cross had helped to improve the health of thousands of persons.

Since it was established in 1937, the plan here has provided benefits for 1,130,000 members for a total of more than 22,000 years of hospital service, Roger Davis, director of public relations, reported. Membership in the association now exceeds 1,570,000, he said.

NEWS...

Patients Are Abusing Blue Cross Privileges, Dr. Hawley Declares

CHICAGO.—Many patients are abusing their Blue Cross memberships "to the point of fraud" and some doctors, "wittingly or unwittingly," are abetting the deception by admitting patients for diagnosis instead of treatment and ordering unnecessary services, Dr. Paul R. Hawley, director of the American College of Surgeons and former chief executive of the Blue Cross-Blue Shield Commission, said in an interview here last month.

Many patients are using their hospital plan memberships for luxury rather than necessary service, Dr. Hawley charged. "There is a curious defect in public morality that makes it no crime to defraud an insurance company," the A.C.S. director declared. "Many people who would be horrified at the very thought of taking one penny from a fellow man have not the slightest compunction about taking money under false pretenses from an insurance company."

Dr. Hawley warned doctors that they are cutting their own throats by sanctioning such abuses of Blue Cross membership. As services increase, he explained, the cost of the membership must go up.

"The day may come when Blue Cross will be too expensive for poor people," Dr. Hawley explained. "When that day comes, there will be compulsory health insurance."

Dr. Hawley said hospital staffs frequently ordered "every conceivable laboratory test" for Blue Cross patients rather than relying on sound physical diagnosis. "When a patient carries no insurance and must pay out of his pocket for unnecessary examinations, some degree of caution is usually exercised, but the Blue Cross patient is fair game," he stated.

Blue Cross protects the patient, Dr. Hawley concluded, and the doctor must protect Blue Cross.

Indiana Bureau Rejects Request of Hospitals for Revision of Insurance Rates

EVANSVILLE, IND. — A request by the insurance committee of the Indiana Hospital Association for revision of rates paid by hospitals was denied by the Indiana Rating Bureau, the association's monthly bulletin reported last month.

In a letter to W. C. McLin of the Methodist Hospital, Indianapolis, the rating bureau reviewed losses paid during the last three years. The average loss ratio on hospital fire insurance policies in the state for the three year period was 45.5 per cent on a premium income of approximately $334,000, the bureau said.

"The experience clearly demonstrated what we pointed out to members of your insurance committee," E. M. Sellers, bureau manager stated, "namely, that any single major loss or series of smaller losses in one year will destroy an otherwise favorable experience as the volume of premiums is not large enough to furnish any true base to determine the adequacy or inadequacy of hospital rates in the state. While continued study will be given the subject, at this time the bureau is not in a position to institute any revisions in rate except where improvements or changes are made in individual risks which warrant rerating."

NEWS...

Missouri Association Elects C. E. Copeland

ST. LOUIS.—C. E. Copeland, administrator of Missouri Baptist Hospital here, was named president of the Missouri Hospital Association at the annual meeting last month. Several hundred hospital people, including 100 hospital trustees and 125 members of women's auxiliaries throughout the state, attended sessions of the two-day conference.

Officers and members of the board of trustees of the Missouri Hospital Association.

At the trustees' meeting, H. J. Mohler, president of the Missouri Pacific Hospital Association, discussed the responsibility of hospital administrators and trustees for control of medical care. Major B. Einstein, president of the board of the Jewish Hospital, St. Louis, discussed the problem from the trustees' point of view.

Dr. Frank R. Bradley, administrator of Barnes Hospital, St. Louis, and a trustee of the American Hospital Association, told the meeting of the negotiations looking toward the development of a new hospital standardization program.

In addition to Mr. Copeland, other officers elected by the associaton were: president-elect, C. Steacy Pickell, Kansas City; first vice president, Herbert S. Wright, Cape Girardeau; second vice president, Dr. David Littauer, Kansas City; treasurer, Rev. E. C. Hofius, St. Louis, and trustee, George Masters, Carthage.

Hospitals Seek $5,500,000

CHICAGO.—A campaign for $5,500,000 for the Michael Reese and Mount Sinai hospitals here was undertaken last month. The money will be used to start a building program for the hospitals, it was explained, including construction of a professional services building at Mount Sinai and a 120 bed addition at Michael Reese. Victor S. Riesenfeld, president of Montefiore Hospital of New York, was the principal speaker at a public meeting inaugurating the joint campaign for the two hospitals.

NEWS...

A.M.A. House of Delegates Appropriates $500,000 for Medical School Needs

CLEVELAND. — A fund of $500,000 has been appropriated by the house of delegates of the American Medical Association as an initial contribution toward private financing of medical school needs. The fund was approved by delegates on recommendation of the association's board of trustees at the annual clinical session here last month.

Objective of the action will be to assist medical schools without recourse to federal subsidy, it was explained. Association officers expressed the hope that business and labor groups and individuals will add to the fund.

"There is a growing awareness that federal subsidy has come to be a burden, not a bounty, and is dangerously increasing federal controls over our institutions and the lives of our people," an association officer said, explaining the action. "American medicine feels very strongly that it should not seek federal aid unless all other means for financing have been exhausted."

In another statement approved by the association, it was denied that a shortage of physicians exists in the United States today. "Medical schools are training enough young men annually and the only problem lies in distribution of available doctors," the association said.

"The association's campaign against socialized medicine will be continued, though the immediate danger has been alleviated by the November elections," association officials stated.

Following the meeting, the Committee for the Nation's Health released a statement describing the A.M.A.'s medical school fund as a "pitiful 1 per cent of what the medical schools themselves have declared essential to expand their freshman classes."

Reviewing the history of legislative proposals providing for federal assistances for medical schools, the committee called the A.M.A. fund a "ridiculous substitute" for the $250,000,000 measure passed by the Senate in 1949 but not subsequently approved in the House of Representatives.

Dr. Elmer Henderson, A.M.A. president, said the association spent $1,110,000 in its advertising campaign prior to the 1950 elections. The campaign would be continued, Dr. Henderson said. The association's publicity agents would be paid additional fees of $300,000 under their present contract.

NEWS...

A.C.S. Warns Armed Forces Against "Extravagance in Provision of Medical Care"

CHICAGO.—Extravagance in the provision of medical care for the armed services must be avoided in the "doctor-draft," a committee of the American College of Surgeons warned in a letter released last month to President Truman and to military and medical officers of the selective service system.

Acknowledging the necessity of providing the best possible medical care for members of the armed forces, the surgeons were nevertheless critical of methods now used. Better unification of medical establishments in the armed service would effect needed economies, it was suggested.

The college group urged the military to adopt a plan similar to that under which veterans hospitals have been located near large centers of population and medical skill, thus making available the services of civilian physicians on a part-time basis. It was also recommended that armed forces casualties should be transferred to veterans administration hospitals as soon as it is possible to determine that further service is impractical.

Withdrawal from teaching hospitals of unnecessarily large numbers of young doctors in the midst of their graduate training should be "scrupulously avoided," the college committee declared. Such physicians are participants in an integrated educational program designed to afford the country a high type of specialist to meet the large demand for their services, the statement said.

The committee recommended that an advisory board of medical educators be established to counsel with selective service leaders on "doctor-draft" problems.

Members of the committee were: Drs. B. Noland Carter, Cincinnati; Loyal Davis, Chicago; Paul B. Magnuson, Washington; Philip D. Wilson, New York, and Evarts A. Graham, St. Louis.

Blue Cross Enrollment Reaches 39,399,662, Commission Director Reports

CHICAGO. — More than 39,000,000 persons in the United States and Canada were enrolled in Blue Cross plans on Sept. 30, 1950, Richard M. Jones, director of the Blue Cross commission, reported here last month. The addition of 813,709 members during the third quarter of the year exceeded third quarter growth last year by 257,128 members, the report said. Total membership numbered 39,399,662 on September 30.

Michigan Hospital Service, Detroit, led all plans in enrollment with the addition of 273,095 members during the third quarter. Associated Hospital Service of New York was second with 70,651 members, and Blue Cross Hospital Service, Indianapolis, was third with 57,476.

Largest percentage increase in enrollment was reported by Arkansas Medical and Hospital Service, Little Rock, which had a 16.07 per cent gain. Michigan Hospital Service, Detroit, and Alberta Blue Cross Plan, Edmonton, reported enrollment gains of 14.53 per cent and 10.77 per cent respectively, it was reported. More than 24 per cent of the United States' population and more than 26 per cent of the population of Canada now are Blue Cross members," Mr. Jones said.

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NEWS...

Northwestern University Offers New Program for Student Nurses

CHICAGO.—Northwestern University's medical school last month announced a new program for nurses, offering a bachelor of science degree in nursing in addition to the diploma in nursing.

Dr. Theodore R. Van Dellen, assistant dean, emphasized that there has been a definite need for such a program. "This course of training will make it easier for women students in nursing to obtain a bachelor of science degree," he said. "The plan will provide better education for nurses and at the same time speed up the course of training."

Candidates for the new degree must have 90 quarter hours in an accredited university and must complete three calendar years in one of the schools of nursing affiliated with Northwestern University. These are Wesley Memorial Hospital and Passavant Memorial Hospital, both located on the Chicago campus, and Evanston Hospital, Evanston, Ill.

Under the new program, residence in Northwestern's college of liberal arts is not required. Credit from any accredited university will be accepted but work in English, chemistry and biology is required.

In addition, Northwestern offers two other nursing programs. In one, students may obtain the diploma of a graduate nurse by spending three years in one of the three hospitals affiliated with Northwestern. The second program, leading to a bachelor of science degree and a nursing diploma, requires that students have two years of liberal arts credits before entering the school of nursing. Under this plan, students must spend one of the two years in Northwestern's college of liberal arts.

The new program was formulated by the council on nursing education. Council members who planned the program include Dr. Richard H. Young, medical school dean; Dr. Van Dellen, Dr. John H. Annegers, Dr. E. T. McSwain, dean of Northwestern's University College, and directors of nursing Edna S. Newman, Wesley Memorial Hospital; Elizabeth Odell, Evanston Hospital, and Miriam Rand, Passavant Memorial Hospital.

General Tate Resigns as Head of American Hospital in Paris

NEW YORK.—Brig. Gen. Foster J. Tate has resigned as manager of the American Hospital in Paris, France, it was reported here last month by the *New York Herald-Tribune*.

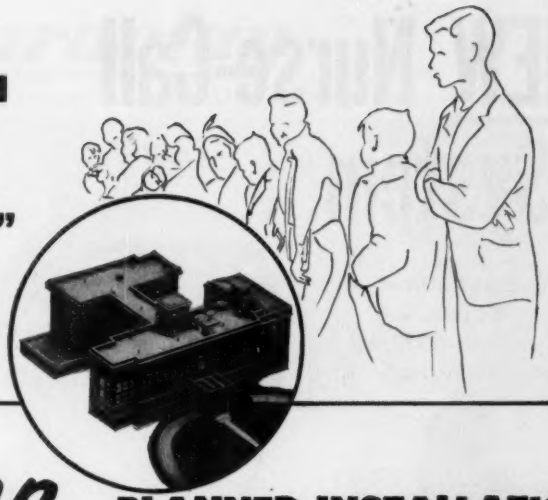
Announcement of General Tate's resignation followed the report that six members of the hospital medical staff had resigned in protest against what was described as the "predominance" of French doctors and technics at the institution. Dr. Beeckman J. Delatour, clinical director of the hospital, described the resignation of staff members as "impetuous and regrettable."

American and Canadian residents in surgery and medicine on the hospital staff complained that French staff doctors used their own assistants in surgery, and, as a result, the residents were not getting the experience they would get in American hospitals.

The American Hospital is located in Neuilly, a suburb of Paris, and is one of the most modern institutions in the French capital.

MODERNIZATION

eased the Laundry "Growing Pains" for Children's Hospital Columbus, Ohio



Hoffman -PLANNED INSTALLATION

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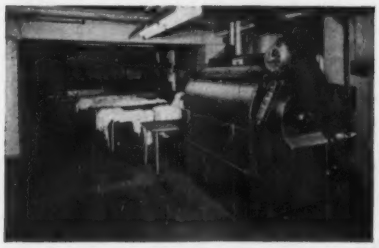
At far left, two new end-loading "Shell-Less" washers to supplement a previously installed 44 x 54 "Shell-Less", which was elevated for faster unloading. At right, a new 40-inch open-top extractor.



Bottleneck in finishing linen was broken by the addition of a 4-roll, 110-inch Hoffman flatwork ironer, a 42 x 60 "Balanced Suction" tumbler and (not shown) a 36 x 30 "Ucon" Tumbler.

A heavy schedule of overtime work, week after week — repeated need for sending laundry to outside processors — these were the "prices" paid by the 200-bed Children's Hospital for increasing service to its community. "What should be done about our laundry operation?"

A Hoffman laundry survey confirmed the fact that occupancy close to 100% (through the admission of adult polio cases) and work from a new nurses' home had established a basic laundry load greater than the existing equipment could handle or stay "caught up" with.

At the request of the Hospital's officials, two sets of plans for modernized laundries were prepared by Hoffman laundry engineers. One, for a new laundry in the existing floor space; the other, for an enlarged laundry in a building extension. Either arrangement provided a laundry operation matched to the needs. However, recalling the painful experiences of their soon-too-small, old laundry, Children's Hospital decided on the building addition. Installation of Hoffman laundry equipment has resulted in a reduction in the laundry work week and linen supply balanced to today's needs — capable of expansion to tomorrow's growth.

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NEWS...

J. C. McGilvary Heads Idaho Hospital Group

TWIN FALLS, IDAHO.—J. C. McGilvary, administrator of Twin Falls County Hospital, was named president of the Idaho Hospital Association at the annual meeting here last month. A large turnout of delegates attended the meetings and took part in the two-day discussion covering civilian defense, economic security for nurses, management of industrial accident cases, and other association problems.

Visitors taking part in the program included Walter Heath of Tacoma, president of the Association of Western Hospitals, Dr. Russell Scott of Lewiston, president of the Idaho State Medical Association, and Leonard P. Goudy, secretary of the council on administrative practice of the American Hospital Association.

In addition to Mr. McGilvary, other officers elected by the association were: president-elect, J. Tiernan, Pocatello; vice president, Sister Richard Joseph, Lewiston; secretary-treasurer, Cornelius Meagher, Boise, and executive secretary, Harold Baumgarten, Idaho Hospital Service.

Colorado Elects Officers

DENVER.—Henry Hill, administrator of the Weld County Hospital at Greeley, Colo., was named president-elect of the Colorado Hospital Association at the 26th annual meeting here last month. Mr. Hill will succeed Louis Liswood, superintendent of the National Jewish Hospital, Denver, who became president during the meeting.

Left to right: Henry Hill, Dr. James P. Dixon, Louis Liswood, and Leonard Goudy.

Other officers named by the association were: vice president, Sister Mary Lina, St. Francis Hospital, Colorado Springs; treasurer, A. Moritz, Denver General Hospital, and executive secretary, Robert A. Pontow, Colorado General Hospital, Denver.

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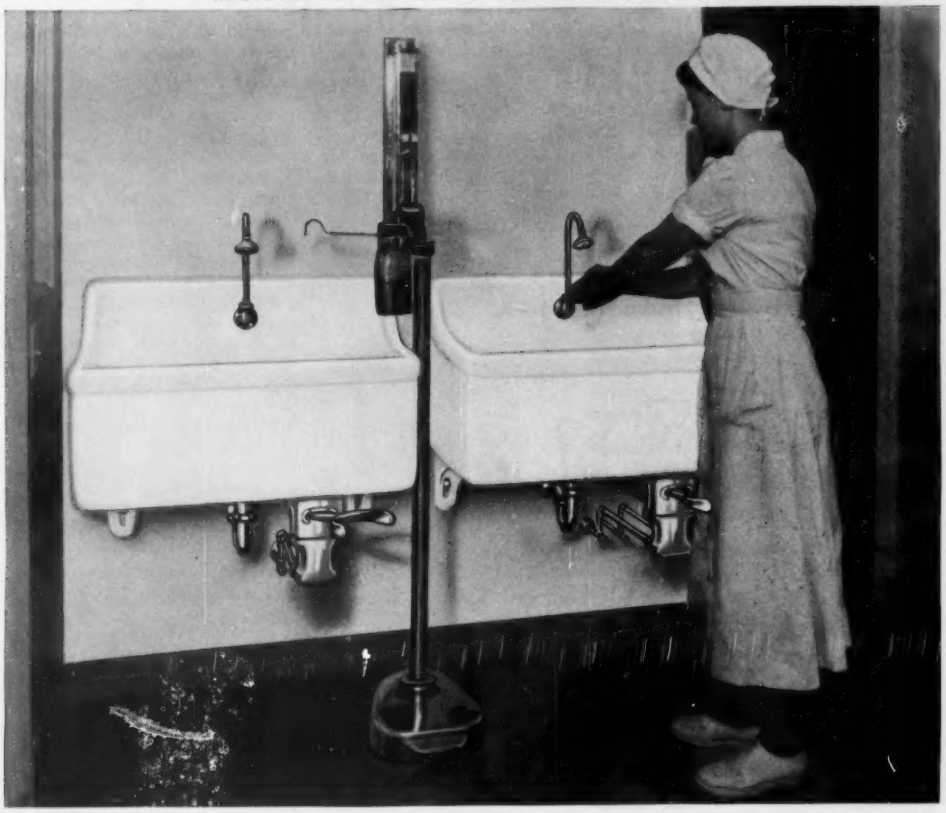

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NEWS...

Rochester Area Group Discusses Hospital Care

ROCHESTER, N.Y.—Doctors, trustees and administrators in the Rochester area of New York State met December 13 in Clifton Springs, to consider the development of better health and hospital care within their communities. The meeting, which was sponsored by the Council of Rochester Regional Hospitals, Inc., was attended by more than 100 persons, a third of whom were physicians. Following a talk by Edward K. Warren, chairman of the board, Greenwich Hospital, Greenwich, Conn., and vice president, Connecticut Hospital Association, on the responsibilities of the board member in establishing policies for hospital care, a general discussion took place.

The discussion was led by a panel comprising Drs. M. Edgerton Deuel, Geneva General Hospital, and Samuel J. Stabins, Genesee Hospital; trustees Frank H. Hamlin, F. F. Thompson Hospital, Canadaigua, and Edward Harris Jr., Rochester General Hospital, and administrators Dr. Basil C. MacLean, Strong Memorial Hospital, and Martha Iver, Corning Hospital. Raymond P. Sloan, editor, The MODERN HOSPITAL, served as moderator.

The general practitioner is assuming a more important position in the hospital program, according to several speakers. There was unanimous agreement that hospitals should encourage the medical man as the custodian of public health in the community. Toward this end a separate department has already been established at Highland Hospital, Rochester, N.Y. Growing interest was likewise manifest in the development of home care programs. George J. Hucker, president of the board of trustees, Geneva General Hospital, and president of the council, predicted that before long such a plan would be developed in his own institution.

Hospitals represented included those in Medina, Brockport, Albion, Seneca Falls, Penn Yan, Elmira, Bath, Dansville, Hornell, Cuba, Wellsville, Rush, Newark and Palmyra.

Nursing School Admissions Total 44,185 in 1950

PHILADELPHIA.—Admissions to nursing schools in 1950 totaled 44,185, the largest class in five years, Theresa I. Lynch, dean of the University of Pennsylvania school of nursing, announced here last month. Miss Lynch is chairman of the Committee on Careers in Nursing.

A survey made by the National League of Nursing Education revealed the 1950 class was 1.3 per cent larger than the 1949 class, Miss Lynch said. Twenty-two states reported increased classes.

Closes Floor Because of Nurse Shortage

NEWARK, N.J.—Beth Israel Hospital here has closed one floor and curtailed admission of elective patients because of the acute nursing shortage, it was reported last month. I. Ellis Behrman, director of the hospital, said that patients were being sent home as promptly as possible but not at any sacrifice of good quality care. In recent weeks, it was reported, the nursing staff was reduced from 40 regular and 40 part-time workers to 51 "regular" and eight "contingent" nurses.

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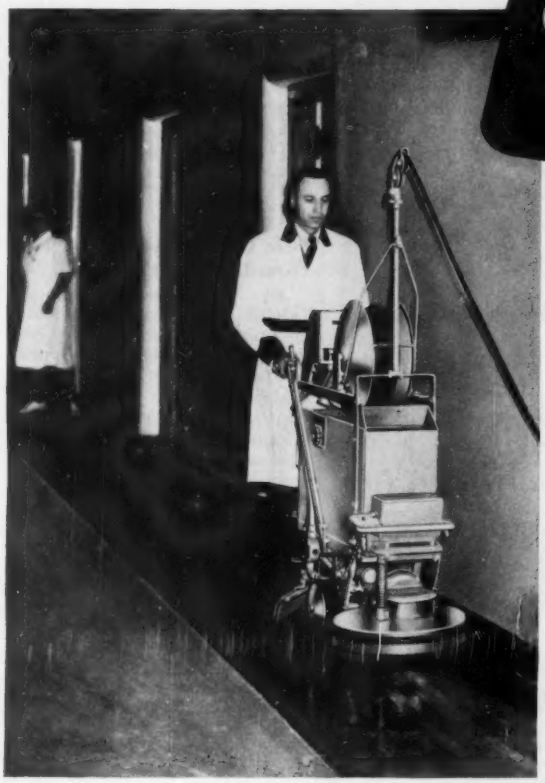

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NEWS...

Eastern Hospitals Isolated By 30 Inch Snowfall

CHICAGO.—A number of hospitals in Ohio, Pennsylvania and other Atlantic Seaboard and New England states were temporarily without utility service when the severe storm that struck the eastern United States last month resulted in power failures in a number of cities.

Hospitals in Cleveland and Pittsburgh were affected most severely by the storm, it was reported. At one Cleveland hospital a power failure occurred during an operation which was successfully concluded by candle light, according to newspaper reports.

Hospital personnel in the affected areas was praised for its efforts to meet the emergency situation. In a communication to employes of Shadyside Hospital, Pittsburgh, William E. Barron, administrator, expressed appreciation to employes and volunteers who worked around the clock during a period when the hospital was virtually isolated by the 30 inch snow storm.

"Many employes worked around the clock and then around again after only a few hours' sleep," Mr. Barron said. "Some walked or hitch-hiked many miles to get here. Realizing that an emergency existed, they pitched in and did everything they could to help. As a result, no patient was neglected.

"Schools, banks, industries and stores can close, and did, but the public expects a hospital to stay open under any and all conditions. As usual, we stayed open and gave all the service required. Our census actually jumped from 295 to 315 patients during the worst of the storm period."

Twin Cities Hospitals Threatened With Strike

MINNEAPOLIS.—Hospitals in the Twin Cities area were operating under emergency regulations permitting only limited admissions following a threatened strike by 2000 members of the A.F. of L. Public Building Service and Hospital Employes Union last month.

Harry L. Hanson, state labor conciliator, said that hospitals and union representatives had failed to make progress toward reconciliation of wage and hour differences for building service workers.

Under the emergency regulation, only maternity, accident and emergency illness cases were being accepted at 11 Minneapolis and St. Paul hospitals involved in the threatened strike, it was explained. Richard J. Leonard, attorney for a group of hospitals, said that the union representatives had rejected compromise proposals providing for a maintenance-of-membership clause as a substitute for the union shop contract demanded by the workers.

New V.A. Hospital Dedicated

WILKES-BARRE, PA.—Carl R. Gray Jr., administrator of veterans' affairs, was the principal speaker at dedication ceremonies for the new U. S. Veterans Administration Hospital here last month. The 480 bed, 11 story general hospital contains extensive facilities for the care and treatment of mental patients, as well as limited facilities for women veterans and for patients suffering from communicable diseases, it was explained. Built at a cost of approximately $14,000,000, the hospital is constructed of reinforced concrete and brick, and is completely fireproof. Kelly and Gruzen, New York, were the architects.

NEWS...

Doctor Dismissed From Staff for Performing Unauthorized Operation

BROWNSVILLE, TEX.—The Mercy Hospital here last month dismissed a doctor from its medical staff following performance of an unauthorized sterilization operation, it was reported.

The dismissal was said to have followed a "stormy operating room scene" between the surgeon and members of the order operating the hospital, who requested that the measures taken to sterilize a patient be undone.

The doctor said the patient had asked for the procedure and that it was "medically advisable," newspaper reports said.

Following his dismissal, the doctor stated his side of the case publicly and a hospital representative replied that the staff member had been denied use of the hospital "for violating a national code of ethics established for Catholic hospitals in regard to these matters."

The case caused widespread comment in the public press. While much of the comment expressed in newspapers was generally favorable to the doctor who had been dismissed, Catholic hospital authorities explained that staff physicians in Catholic hospitals commonly subscribe to a code of ethics under which such procedures may not be performed unless they involve the "necessary removal of diseased organs" and unless hospital authorities have been advised in advance that the procedure is to be performed. One Catholic hospital leader expressed the thought that it was unlikely the doctor would have been removed from the staff if this had been the first instance of code violation.

Fund Raising Goal Exceeded by $40,000

GALLIPOLIS, OHIO.—A campaign for $500,000 to build a new wing for the Holzer Hospital here exceeded its goal by more than $40,000, Wayne B. Foster, hospital administrator, reported last month. Directors of the hospital foundation met following successful conclusion of the campaign to decide on details of the plan for hospital expansion, Mr. Foster said.

At the final meeting of the fund raising campaign organization, more than 300 citizens attended a rally at the city park, where campaign officials announced results of the program.

NEWS...

Defense Department and Red Cross Cooperate on Blood Handling Program

WASHINGTON, D.C.—The Department of Defense has completed an agreement with the American Red Cross looking toward expansion of facilities for furnishing blood to the armed forces, it was announced here last month.

Under the agreement, Defense Department funds will be provided for the collection and handling of whole blood for overseas shipments and for stockpiling plasma, it was explained. None of the funds is to be used in payment for blood which is contributed by volunteer donors and no funds will be used for the Red Cross civilian blood program, the Defense Department stated.

To enable the Red Cross to go forward immediately with expansion of its blood collecting and handling facilities, an advance of $3,000,000 from government funds is provided under the agreement.

COMING MEETINGS

ALABAMA HOSPITAL ASSOCIATION, Hotel Thomas Jefferson, Birmingham, March 9, 10.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, St. Louis, Sept. 17-20.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, St. Louis, Sept. 16-20.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, St. Louis, Sept. 15-17.

AMERICAN HOSPITAL ASSOCIATION MIDYEAR CONFERENCE, Drake Hotel, Chicago, Feb. 9, 10.

AMERICAN HOSPITAL ASSOCIATION, St. Louis, Sept. 17-20.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Congress Hotel, Chicago, March 1, 2.

ANNUAL CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS, Buena Vista Hotel, Biloxi, Miss., April 16-18.

ANNUAL CONGRESS ON MEDICAL EDUCATION AND LICENSURE, Palmer House, Chicago, Feb. 12, 13.

ARIZONA HOSPITAL ASSOCIATION, Adams Hotel, Phoenix, Feb. 16, 17.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs National Park, May 15, 16.

ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Congress Hotel, Chicago, Feb. 28, March 1.

ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, April 30-May 3.

CAROLINAS-VIRGINIA HOSPITAL CONFERENCE, Roanoke Hotel, Roanoke, Va., April 26, 27.

CATHOLIC HOSPITAL ASSOCIATION, Philadelphia, June 2-5.

GEORGIA HOSPITAL ASSOCIATION, Biltmore Hotel, Atlanta, Feb. 23, 24.

INDIANA HOSPITAL ASSOCIATION, French Lick Springs Hotel, French Lick, May 23, 24.

INTERNATIONAL HOSPITAL FEDERATION, Brussels, July 15-21.

KENTUCKY HOSPITAL ASSOCIATION, Kentucky Hotel, Louisville, April 3-5.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Statler Hotel, Washington, D.C., Nov. 26, 27.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, Jan. 26.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 23-25.

MIDWEST HOSPITAL ASSOCIATION, President Hotel and Municipal Auditorium, Kansas City, Mo., April 11-13.

NEBRASKA HOSPITAL ASSOCIATION, Paxton Hotel, Omaha, Nov. 15, 16.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 26-28.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 24.

NEW MEXICO HOSPITAL ASSOCIATION, La Fonda Hotel, Santa Fe, May 18, 19.

NEW YORK STATE DIETETIC ASSOCIATION, Hotel Utica, Utica, N.Y.

OHIO HOSPITAL ASSOCIATION, Netherland Plaza Hotel, Cincinnati, April 2-5.

SOUTHEASTERN HOSPITAL CONFERENCE, Vinoy Park Hotel, St. Petersburg, Fla., April 4-6.

SOUTHWIDE BAPTIST HOSPITAL ASSOCIATION, COMMISSION OF BENEVOLENT INSTITUTIONS OF THE EVANGELICAL AND REFORMED CHURCH, ASSOCIATION OF EPISCOPAL HOSPITALS, Congress Hotel, Chicago, Feb. 28, March 1.

TENNESSEE HOSPITAL ASSOCIATION, Read House, Chattanooga, May 3-5.

TEXAS HOSPITAL ASSOCIATION, Municipal Auditorium, San Antonio, April 24-26.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 30-May 2.

UPPER MIDWEST HOSPITAL CONFERENCE, Nicollet Hotel, Minneapolis, May 16-18.

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Vegetable without Meat ● Vegetable
Beef Noodle ● Beef with Vegetable
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Cream of Mushroom
Clam Chowder ● Cream of Chicken

Ask Your Heinz Man About

HEINZ *Condensed* SOUPS

82 YEARS OF FINE QUALITY

NEWS...

V.A. to Make Use of Facsimile X-Ray Films

WASHINGTON, D. C.—Mass production of facsimile x-ray films was announced here last month by the Veterans Administration. The V.A. said that the facsimile films were "professionally accepted" and would enable the department to speed examination and treatment of veterans and protect original films against loss or damage through handling and transportation while claims are being considered.

Hereafter, when a V.A. hospital or doctor needs an x-ray film developed previously for examination or treatment of a claimant, the request will be sent to the V.A. records center at Philadelphia, where a facsimile will be made for the hospital or doctor and the original will be retained at the records center, the report said.

Facsimiles are made by means of a "solarization" process originally developed by Dr. William H. Roper, director of the section for research on minimal tuberculosis of the Army Medical and Development Board, it was explained. Present production capacity at the records center is 80 to 100 facsimiles a day. With additional personnel, the figure can be raised to 400, the V.A. said.

Release Simplified List of Surgical Sutures

WASHINGTON, D.C. — A simplified list of types and sizes of surgical sutures in major demand by hospitals for general surgery has been released by the Commodity Standards Division of the Office of Industry and Commerce, U.S. Department of Commerce, the division reported here last month. The list is identified as "Simplified Practice Recommendation R239-50, Surgical Sutures, Nonboilable Type (Catgut, Silk and Nylon)" and covers about 95 per cent of total sales of sutures of these kinds, it was explained.

The program to establish a simplified list of standard stock sizes of sutures was initiated by the purchasing, simplification and standardization committee of the American Hospital Association, and was developed in cooperation with the manufacturers and the American College of Surgeons. A substantial list of hospitals, manufacturers, distributors and others interested have accepted this recommendation, the division stated.

The division has also announced the adoption of a new standard for plastic tableware. This is Commercial Standard CS173-50 for Heavy-Duty Alpha-Cellulose-Filled Melamine Tableware. The standard includes requirements for thickness, finish and resistance to boiling and heat.

Mountainside Affiliates With Regional Center

NEW YORK. — Affiliation of the Mountainside Hospital, Montclair, N.J., with the New York University-Bellevue Medical Center was announced here last month. The Mountainside Hospital is the fourth New Jersey institution to join the medical center's regional hospital plan, it was explained.

Announcements were made jointly by Dr. H. M. Wortman, Mountainside director, and Dr. Clarence E. de la Chapelle, director of the medical center's regional hospital plan.

The plan is part of the medical center teaching program and aims at keeping affiliated hospital staffs abreast of latest advances in medical care.

NEWS...

Call Conference to Study Prevention of Chronic Illness

CHICAGO.—A national conference has been called to explore ways of preventing chronic disease, Dr. Morton L. Levin, staff director of the Commission on Chronic Illness, announced here last month. The conference will be held in Chicago, March 12 to 14, 1951. Co-sponsors are the National Health Council and the United States Public Health Service.

Discussions at the conference will be based on authoritative summaries of present day scientific knowledge regarding prevention and early detection of major chronic diseases, including cancer, heart disease, arthritis, rheumatism, poliomyelitis, multiple sclerosis, cerebral palsy, epilepsy, diabetes, blindness, deafness, tuberculosis and syphilis, Dr. Levin said. Emotional factors in chronic disease, malnutrition, including obesity, heredity in chronic disease, and occupational causes of chronic disease, will also be considered, he said.

A.H.A. Issues Leaflet Explaining Social Security

CHICAGO.—A booklet entitled "Why Every Hospital Employe Should Have Social Security" has been released by the American Hospital Association to help member institutions explain social security to hospital employes. The booklet includes several pages of questions and answers about social security payments and benefits and also includes a section on "how to join the social security program."

In an accompanying memorandum, the association urged member hospitals to focus employe attention on social security through meetings, publications, displays and personal contact. "Don't try to be an expert on social security," the memorandum warned. "It's very complex. You'll find the major benefits outlined in the leaflet. For difficult questions or details about specific cases, contact your local social security office."

University of Chicago Opens New Cafeteria

CHICAGO.—A new cafeteria and kitchen installation serving the University of Chicago Medical Center and Hospitals was opened here last month, Ray Brown, superintendent of university hospitals, reported. The designed area is planned to accommodate 350 persons and will serve 1200 during a single meal, including outpatients, visitors and employes of the university hospital group, it was explained.

The new cafeteria and kitchen facilities are located in the basement of the inner court of Billings Hospital, Mr. Brown said, and connect with corridors of outlying wings. The new installation will also serve a gift shop to be located on the first floor of the hospital. Schmidt, Garden and Erickson of Chicago were architects for the project.

Presbyterian Fund Drive Reaches Half-Way Mark

CHICAGO.—Gifts totaling $2,700,000 toward the $5,500,000 objective of the Presbyterian Hospital's building fund campaign were announced here last month. Mrs. Allin K. Ingalls, chairman of the special gifts organization in the campaign, said the money will be used to expand hospital facilities and finance the new nurses' home now under construction.

ABOUT PEOPLE

(*Continued From Page 76.*)

tion from Northwestern University and served his administrative residency at Milwaukee County Institutions in Wisconsin.

Charles D. D'Spain is resigning as assistant administrator of Memorial Hospital, Rock Springs, Wyo., to become administrator of Cody Hospital at Cody, Wyo., on January 15. Mr. D'Spain was at Memorial Hospital for a year and, prior to that time, was an accountant at the University of Colorado Medical Center, Denver.

Howard B. Hatfield resigned as administrator of San Pedro Community Hospital, San Pedro, Calif., to become administrator of Long Beach Community Hospital, Long Beach, Calif. Mr. Hatfield succeeded **Sarah A. Ruddy,** who retired November 15 after 21 years as administrator of the Long Beach hospital.

Gerhard A. Krembs, in addition to his post as administrator of Door County Memorial Hospital, Sturgeon Bay, Wis., is serving as part-time administrator of Algoma Hospital, Algoma, Wis.

Elmer Matthews, former superintendent, Wilkes-Barre Hospital, Wilkes-Barre, Pa., has been elected president of the board of directors of the Knox County Community Hospital, Rockland, Me.

Mrs. Hazel Ferguson has been elected managing director of the Cradle Society of Evanston, Ill. Mrs. William B. Walrath, managing director of the Cradle since she founded it in 1923, is to continue on the board with emeritus status. Mrs. Ferguson has been a director of the institution since 1937 and secretary for 10 years.

Dr. Milton E. Goldstone has been appointed assistant administrator of the Hospital for Joint Diseases, New York City. Prior to his appointment, Dr. Goldstone was in resident training in various aspects of medicine in hospitals throughout New York City as well as at the Hospital for Joint Diseases.

Dr. Don E. Nolan, chief of professional services at the Veterans Administration Center, Dayton, Ohio, has been named manager of the V.A. hospital now under construction at Seattle. The hospital is expected to receive its first patients in April. Dr. Nolan is assistant professor of internal medicine in the University of Cincinnati Medical School and a diplomate of the American Board of Internal Medicine.

Dr. J. Crosby Johnston

Dr. J. Crosby Johnston has been appointed an assistant superintendent at Stanford University Hospital. Dr. Johnston graduated in medicine from the University of Alberta prior to World War II, in which he did medical and medical administrative work in the Royal Canadian Air Force. He continued his interest in administrative work in the early postwar years and completed formal administrative training in the University of Toronto course in hospital administration. Dr. Johnston holds personal membership in the American Hospital Association.

Department Heads

Barbara Janata, R.N., has been appointed director of nursing at Baroness Erlanger Hospital, Chattanooga, Tenn. Other new appointments at the hospital include those of **Elizabeth Shaw** as hospital librarian and **Betty Snyder** as executive dietitian.

John A. Rose has been appointed personnel officer, Royal Victoria Hospital, Montreal, Que. For the last two years Mr. Rose has been assistant district personnel officer in the Department of Veterans Affairs at London, Ont.

John A. Rose

Ruth Newell is the new director of personnel at Rochester General Hospital, Rochester, N.Y. Miss Newell has been active in organizing and conducting personnel programs with several large organizations for the last eight years.

Frances L. Loftus, R.N., formerly director of nurses at Memorial Hospital, Cumberland, Md., has been appointed director of nurses at Wilmington General Hospital, Wilmington, Del. She succeeds **Jane K. Smith, R.N.,** who resigned after serving as director of nurses at Wilmington since 1947.

Dr. Herman J. Bearzy has been named director of the department of physical medicine and rehabilitation at Miami Valley Hospital, Dayton, Ohio, assuming his duties there on January 1. Dr. Bearzy's predecessor, **Dr. Bert C. Wiley,** has assumed the position of director of physical medicine, Acuff Clinic, Knoxville, Tenn.

Miscellaneous

James E. Bryan resigned as executive officer of the Medical Society of New Jersey to become administrator of the Medical-Surgical Plan of New Jersey on November 1.

Dr. David E. Price has been appointed an assistant surgeon general of the Public Health Service and an associate director of the National Institutes of Health. **Dr. Norman H. Topping,** associate director of the National Institutes of Health for the last three years, will continue in that capacity and will assist the director, **Dr. William H. Sebrell,** with the intramural research program. Dr. Price will assist Dr. Sebrell in extramural operations.

Deaths

Agnes Isabelle Byrne, director of Roosevelt Hospital School of Nursing, New York City, for 17 years until her retirement in 1947, died November 21 after a long illness. She was 68 years old.

Frederick T. Muncie, past president of the American Association of Hospital Accountants and program officer for the Illinois chapter, died suddenly December 4 in Chicago. For many years Mr. Muncie was chief accountant at St. Luke's Hospital, Chicago.

General Motors Sets Up Fund for Research on Employes' Health

DETROIT. — The General Motors Corporation has established a $1,500,000 research program to promote better health for G.M. employes and other industrial workers, it was announced here last month. The program will be conducted jointly with the University of Michigan and is established as the Institute of Industrial Health at the university, it was explained.

Objectives of the program are expansion of employe health facilities, research and education in industrial medicine, health and safety, the announcement said.

Of the total amount given to the university by General Motors, $500,000 will be used for equipment, and payments of $100,000 a year for 10 years will be made for fellowships, scholarships and other pay-roll and operating expenses.

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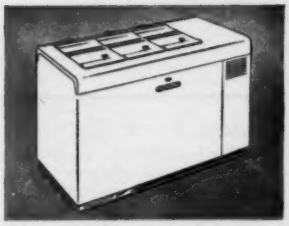

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Frigidaire Ice Cream Cabinets keep ice cream at just right temperature for fast serving—provide safe storage for frozen food. Shelves, dividers, and baskets provide convenient individual storage sections. These Frigidaire Cabinets are also powered by the efficient, economical Frigidaire Meter-Miser. Capacities of these low-temperature cabinets range from 4.8 cu. ft. to 18 cu. ft.

Window Conditioners Help Patient Morale

Frigidaire Window Air Conditioners add to patients' comfort and morale by cooling and dehumidifying the air in their rooms. These compact window conditioners also filter dust, dirt and pollen from the air—help keep rooms healthfully clean. Powered by the Frigidaire Meter-Miser, the thrifty units operate on a trickle of current.

Simplest Cold-Making Mechanism Ever Built

On this page are a few of the many Frigidaire products powered by the world-famous Meter-Miser Compressor. Sealed in steel and oiled for life, it has set records for low-cost, trouble-free service in millions of Frigidaire products—is backed by a 5-Year Warranty. Frigidaire Meter-Misers are also available separately in ¼, ⅓ and ½ hp sizes for easy installation in existing refrigeration units. (Also Frigidaire reciprocating compressors up to 25 hp.)

THE BOOKSHELF

FINANCIAL STATUS AND NEEDS OF MEDICAL SCHOOLS. *A Preliminary Report by the Surgeon General's Committee on Medical School Grants and Finances. Federal Security Agency, Public Health Service. Washington, D.C.:* 1950.

This preliminary report of the committee on medical school grants and finances, appointed by the Surgeon General of the U. S. Public Health Service, was undertaken on the recommendation of the National Advisory Health Council. The committee worked closely with the American Medical Association's committee on survey of medical education, and the Association of Medical Colleges.

The study covered the operations for 1947-48 of 79 medical schools in which 23,054 undergraduate students were enrolled. Of the 79 schools, 72 offered the regular four-year program in medical education, and seven offered instruction in the basic science courses only; 68 were affiliated with university organizations, while 11 were separate schools, and 35 were under public control, 44 being privately controlled. The average size of student body was slightly over 300, the largest being 653 students and the smallest, 148.

Certain problems in collecting data were recognized by the survey staff at the outset, and methods were devised to obtain as nearly comparable data as possible. The report discusses each of these problems at considerable length.

First was the lack of uniformity in financial reports. Accounting and reporting systems of these institutions varied greatly in form and content, although a large degree of uniformity was seen in that many followed the suggestions of the National Committee on Standard Reports for Institutions of Higher Education.

Second was the lack of uniformity in relationships between medical schools and affiliated clinical facilities. In some cases the hospitals financed a large portion of the clinical faculty positions, while in others the hospitals provided space for many of the school's activities. Where a hospital was provided by the institution, the deficits in the operations of the hospital usually were financed either by the medical school or by the university. The interrelations between these various units and functions were not generally reflected in the financial accounts of the medical school, and allocations of expense and income had to be accomplished by the finance officers of the institutions.

A third problem was the lack of financial data and information on the services and facilities provided by organizations outside the medical school, such as other departments and colleges within the university organization. Wide variations exist in the degree of affiliation of medical schools with parent universities. Some are closely tied in with the universities of which they are parts, while in others, the relationship is nebulous. In the various types of affiliation the financial accounts of the institutions rarely reflected the monetary value of the services exchanged between the units.

Organizations outside the medical school frequently perform services for the school. In one case, for example, all the teaching and research in two departments of instruction are done by an outside organization with no reflection in the financial records of the school of the expenditures for such work. Considerable effort was made to ascertain data from these outside affiliated agencies.

Finally, there were the usual problems in cost studies of allocating general administrative charges, library expenditures, and expenditures for the operation and maintenance of the physical plant to a teaching department which is only one of many departments in a complex university organization.

After considerable thought and discussion, the survey staff decided to confine the major part of the study to expenditures for the basic undergraduate program of instruction, including in their computations (1) expenses for salaries, supplies and equipment for direct classroom and laboratory teaching, (2) expenses for the direct administration of the medical school and a share of general university administration in the affiliated schools, (3) operation and maintenance of the physical plant used by the medical school, and (4) the library services provided for students and faculty of these schools. As far as possible, the survey staff excluded from the basic computations expenditures for separately budgeted research, clinical facilities, hospitals, postgraduate instruction (where separately organized and budgeted), and noneducational activities. These expense items were discussed separately.

CURRENT EXPENDITURES

In 1947-48 the 79 medical schools included in the study spent a total of $53,450,807 for the undergraduate instructional program. More than 80 per cent of this sum was spent by the four-year medical schools, only $1,030,557 being involved in the seven basic science schools. Analysis of the distribution of expenditures among the four instructional functions showed that there was little difference between the publicly controlled institutions and the private.

Expenditures per student for the undergraduate instructional program were computed in 70 of the 72 four-year schools, 27 being under public control and 43 under private. The average (mean) expense per student was $2285; in the public schools it was $2432, and in the private, $2196. The highest expenditure per student, $8257, was more than 10 times greater than the lowest, $754. The range from the first to the third quartiles was from $1368 to $2658.

Expenditures per student for direct instructional activities were computed for the same group of schools. Again great variations among the institutions were the rule. The highest expenditure per student, $5848, was more than 11 times greater than the lowest, $492; the range from the first quartile to the third was from $844 to $1952; the average (mean) was $1560.

During the same year a total of $17,132,148 was spent for separately budgeted research by the 79 schools. Practically all of it was spent in the four-year schools, only $27,575 being spent in the basic science schools. The report points out that, in general, the larger the total operating budget of a medical school, the higher the proportion of funds expended for research. Also, separately budgeted research appears to be concentrated in relatively few institutions. Twelve schools each spent more than half a million dollars during the

year for this function, and their combined expenditures accounted for more than half of the total spent by the 79 schools, while only 3 per cent of the total was expended in 21 schools, each spending less than $50,000 for this function.

CURRENT INCOME AND SUPPORT

The survey developed a concept of basic income which constitutes an important frame of reference for identifying and measuring the sources of income for the support of medical schools. The report stated that, although this basic operating income unit is admittedly an arbitrary concept, it is as satisfactory as any other measure now available on the support of medical schools, and provides a means of identifying the source of support in meeting the basic operating expenditures of the school.

During 1947-48 the general operating funds of the medical schools provided little support (3 per cent of the total) for the separately budgeted research activities. Practically all the support (91 per cent) came from designated gifts and grants for research, and from research contracts. A small proportion of the support (6 per cent) was in the form of income from restricted endowment funds.

CHANGES FROM 1940-41 TO 1947-48

A comparison of operating expenditures and income in 1947-48 with those in 1940-41, the last full academic year before World War II, gives some indication of the financial problems now facing these institutions. Reliable and accurate financial data for the first year were available in 54 of the four-year schools, and the comparisons reported cover only those institutions.

Expenditures almost doubled from 1940-41 to 1947-48, the increase for the basic undergraduate instructional program amounting to 94 per cent. Increases in costs of supplies and commodities, increases in salaries, and expansion of activities of the schools were the factors contributing to this increase in total operating expenditures.

Income from tuition and fees increased 36 per cent during the same period, but declined from 35 per cent to 25 per cent as a source of total income for the basic operating programs. Although endowment funds increased $37,922,385 and the income from these funds also increased, this income provided a smaller share of the total income, decreasing from 24 per cent in 1940-41 to 14 per cent in 1947-48. The usual differences between publicly and privately controlled institutions were found in respect to sources of support.

NEEDS OF MEDICAL SCHOOLS

The needs of medical schools as reported by administrative officers were summarized in the following statements:

1. Nearly all schools reported need of additional funds for construction of plant facilities, as well as for current operating budgets, if they are to maintain their present standards of training, or improve them. This need was reported by the larger and presumably well financed schools as well as by the smaller.

2. Thirty-three schools have had to curtail their programs, and others have postponed essential improvements, because of lack of funds.

3. It is estimated that the schools need about $330,000,000 for the construction of facilities and $40,000,000 annually for current operations. In 34 schools, the average amount needed for construction amounted to $4,400,000 per school.

4. Plans to increase freshman enroll-

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ments are being considered by 55 medical schools. The increase would be about 1475 freshmen, which is 32 per cent of the freshman enrollment of the 55 schools, and 22 per cent of the freshman enrollment in the 79 schools included in the study. However, this increase would necessitate approximately $244,000,000 for new construction and $18,000,000 for current operating budgets.

5. The most serious obstacles to increasing freshman enrollments, as cited by the deans and administrative officers of these schools, were, in the order of frequency of mention, lack of space, needed additional faculty, and lack of equipment.

A CENTURY OF NURSING. *By Abby Howland Woolsey* (1876), *Pp.* 172. *Reproduced with the permission of the State Charities Aid Association, New York, and the Bellevue School of Nursing Board of Managers. New York: G. P. Putnam's Sons,* 1950.

The reproduction of a "Century of Nursing" (1876), which throws much light on the development of the modern hospital and on the introduction to modern nursing, is particularly significant coming at this time.

This book, written by Abby Howland Woolsey, a pioneer in the movement for better hospitals and nursing reform in this country, is actually Miss Woolsey's official report to the Standing Committee on Hospitals, State Charities Aid Association of New York, of hospital conditions and nursing systems as observed by her in Europe and in the United States in 1876. In addition the book contains the colorful and interesting story of the founding of the Bellevue Training School for Nurses taken from Elizabeth Christopher Hobson's book, "Recollections of a Happy Life." Also included is Florence Nightingale's historic letter on the Bellevue School written to Dr. Wylie in 1872.

An interesting foreword, by Isabel M. Stewart, chairman, committee on early nursing source materials, National League of Nursing Education, and Agnes Gelinas, president, National League of Nursing Education, contains interesting data about the author. Also contained in the foreword is an expression of appreciation for "the interest shown by G. P. Putnam's Sons in making these classics available to a wider circle of readers and students."

Such readers, who will undoubtedly include many of those currently concerned with the further improvement of hospitals, schools of nursing, and more effective systems of health care, will welcome these encouraging reports of earlier "struggles" in the field.

The question with which Miss Woolsey opens her report, "What shall we do to secure good hospital nursing?" will strike a responsive chord in the hearts of her followers, as will her attempt to answer the question, first by an honest appraisal of existing conditions and second by carefully thought out recommendations for future planning. The latter report on the "Organization of a Training School," together with Miss Hobson's story of the founding of the Bellevue program and Miss Nightingale's letter, tells the interesting story of how these fine people attempted to answer the old but ever new problem of good nursing care.

This volume, which is one of several in the series of historical materials suggested as a memorial to M. Adelaide Nutting, is indeed a fitting tribute to Miss Nutting and a timely contribution to those currently concerned with an appraisal of present health facilities and with plans for improvement of health care.—ELLEN CREAMER.

Greetings AND WARM *Personal Wishes*

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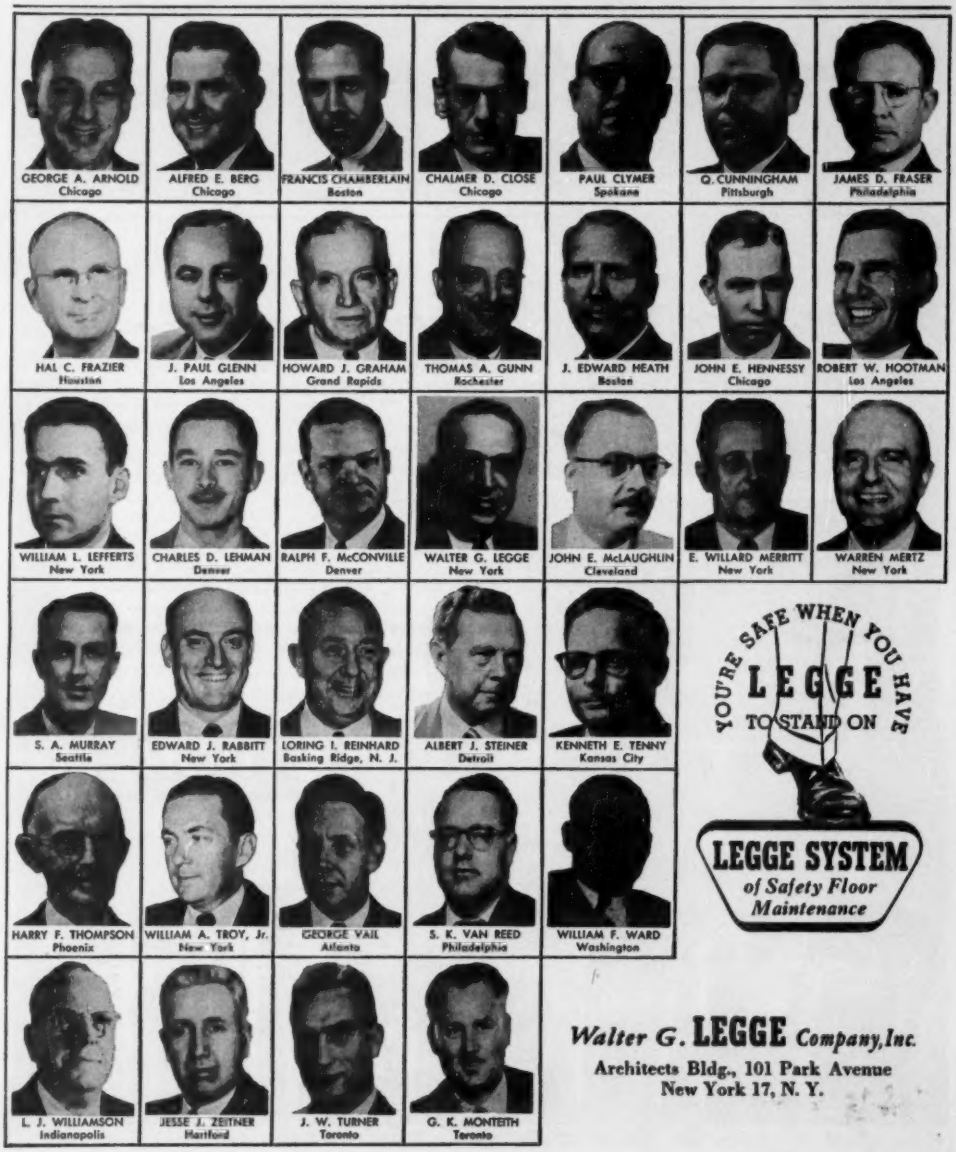

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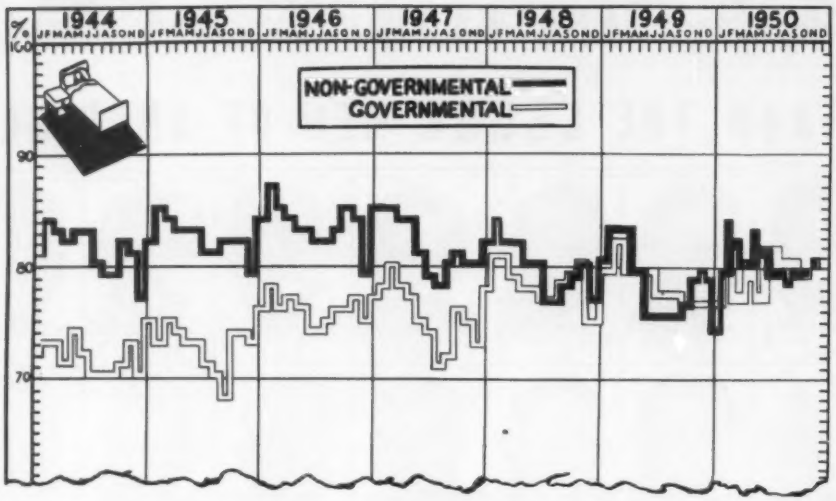

Occupancy of voluntary hospitals reporting to The MODERN HOSPITAL for the month of November was 80.7 per cent of capacity, slightly less than the occupancy for the previous month but above the figure reported for November last year. Governmental hospitals reported 81 per cent occupancy for the month.

Hospital construction reported for the two-week period ending December 4 totaled $59,755,786, bringing the total for the year to $835,174,545—an increase of 64 per cent over construction reported during the same period in 1949. Of 56 projects reported for the latest period in 1950, 18 were new hospitals costing a total of $21,982,600.

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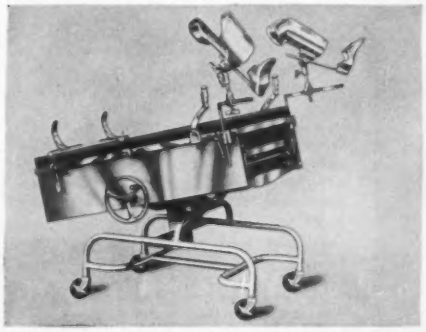

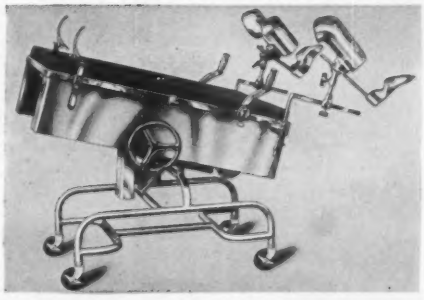

Hand wheel on either side, operating a gear mechanism, quickly adjusts the top from horizontal to Trendelenberg or reverse Trendelenberg positions. The shape of the welded tubular frame permits ample foot room all around the table.

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SHAMPAINE CO. *Sold through Surgical and Hospital Supply Dealers* SAINT LOUIS · MISSOURI

Mechanizing with MONEL helps provide plenty of

Photo courtesy of American Laundry Machinery Company and Stockton State Hospital

STERILE LINEN for a 5,000-BED HOSPITAL

You're looking down the line in the laundry department at Stockton State Hospital, Stockton, California.

Modern in every detail, this department handles more work than a good many commercial laundries.

It has to, in order to supply fresh-laundered, sterile-clean linens fast enough to meet the demands of a 5,000-bed institution.

Streamlined Operation. The equipment in use at Stockton State Hospital is designed for speed and economy. It is *mechanized*. It saves time... labor... water ... power ... supplies. There's improved washing quality, too ... and reduced wear and tear on linens.

You can see practically all of Stockton State's mechanized equipment in the picture. On the left are 4 *Cascade* Automatic Unloading Washers with "Companion Controls." Next, a Rotaire Continuous Shakeout and Conditioning Tumbler. In the background, 2 *Streamline* Flatwork Ironers, each with Trumatic Folder which automatically quarter-folds large linens lengthwise as they come from ironers. And on the right, inside the guard rail, 3 *Notrux* Extractors.

What Mechanization Means. With the automatic Washing Controls, only 3 simple operations are necessary for each load washed. Then, the washman can leave the machines unattended until the loads are ready for removal.

The pushbutton-operated washers unload *automatically* into extractor containers in less than 60 seconds. With pushbutton-loaded and unloaded extractors, there's another saving—often as much as 22 man-minutes a load.

Supplies Conserved. There's no guesswork about the amount of supplies to use. They're measured *mechanically*. Careless or hurried employees can't skimp on them, can't waste them. And washing cycles are set in advance, so the timing is always accurate.

A Sound Investment. Because this mechanized equipment is made of MONEL®, linens are safe from damage. Stronger and tougher than structural steel, Monel is non-rusting. It resists corrosion by soaps, detergents, alkalis, starches, dilute bleaches and fluoride sours. Washer cylinders and extractor baskets stay smooth, don't develop pits and rough spots.

These, as you probably know, are the same characteristics that make Monel so useful throughout the hospital. It looks good — and stays good — year after year.

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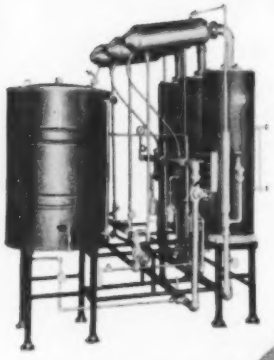

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Ivory Soap's well-earned reputation for purity and gentleness is no news to hospital authorities. For Ivory has helped make millions of hospital patients more comfortable in the past 70 years.

Today's Ivory is a finer soap than ever before. In addition to its traditional purity, Ivory lathers more generously—even in hard water. The smartly styled cake is easier to handle and handsomer than ever.

Yet with all its improvements today's Ivory still costs surprisingly little. Its purchase puts no undue strain on even the most modest hospital budget.

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Pure, mild, rich lathering Ivory Soap is available for hospital use in the popular unwrapped 3-ounce size, as well as in smaller sizes, wrapped or unwrapped. Today's Ivory is finer than ever —richer lathering, handsomer, easier to handle.

MORE DOCTORS ADVISE IVORY SOAP THAN ALL OTHER BRANDS TOGETHER

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3 double-bulge Heat-Treated tumblers offer a sure grip, even when wet: 9½ oz. (water), 12 oz. (iced tea), 5 oz. (juice).

All Libbey Heat-Treated tumblers have this special "H-T" marking—your assurance of 3-5 times longer-lasting glassware.

The young patient's hands are still unsteady. She is thankful for a glass that is light and easy to hold.

Libbey Heat-Treated tumblers have thin sides and bottoms. This feature gives them lightness . . . makes them a real comfort for bedridden patients. And at *no* sacrifice in strength and durability, because Heat-Treated tumblers are specially processed for extra toughness! They stand up 3-5 times longer than ordinary tumblers in heavy hospital service:

All Libbey tumblers have *Safedge* rims—at the spot where most glassware chips first! *Safedge* means "safety" for patients and staff alike. It also means savings through lower initial cost, less breakage and smaller inventory . . . backed by the famous guarantee: *"A new glass if the rim of a Libbey 'Safedge' glass ever chips!"* Ask your supplier for samples and prices, or write direct to Libbey Glass, Toledo 1, Ohio.

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Want Advertisements

POSITIONS WANTED

ADMINISTRATOR—Assistant; 7 years' hospital experience, 13 years' business experience, including legal, investment counsel, real estate, insurance and hospital; thorough knowledge all phases business office procedure; established record credits, collections and public relations; college girl, 34 years old, single; free to change location. MW 24, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSES—B.S.; M.A.: N.Y.U. experience as instructor and as administrator in schools of nursing and nursing services; eastern states. MW 26, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MEDICAL WRITING — Bibliographies, abstracting, editing, ghost-writing, medical, dental, pharmaceutical; long experience; satisfactory work guaranteed; rates reasonable. F. A. Cookaley, Box 634, Washington 4, District of Columbia.

PERSONNEL DIRECTOR — Assistant; five years' teaching experience, four years' experience counselor for student and graduate nurses; Masters Degree Counseling and Guidance; prefer mid-west. MW 25, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

THE MEDICAL BUREAU
Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATOR—Medical; A.B., M.D. Degrees, eastern schools; four years, assistant administrator, 16 years, administrator, large, teaching hospital; experience includes ten years as professor, Hospital Administration; FACHA.

ADMINISTRATOR—Degree in Business Administration; since 1940, director, 350-bed hospital; excellent experience in modernization, enlargement and planning of hospital facilities, fund raising, public relations; FACHA.

ADMINISTRATOR—A.B., Eastern university; year's graduate work, Sociology, Statistics, Harvard; M.S. Hospital Administration, Columbia; internship, three years, assistant administrator, 500-bed hospital; prefers directorship hospital of 100-150 beds or assistantship in larger one.

ASSISTANT ADMINISTRATOR — Graduate nurse; B.S., Hospital Administration; four years' supervisory experience before specializing; recently completed administrative residency, teaching hospital; in thirties.

ANESTHESIOLOGIST—Training received at eastern university medical center; past six years, director of anesthesiology, 800-bed hospital; has passed Part I, American Board.

DIETITIAN—B.S., eastern university; university hospital dietetic internship; 11 years' experience; past six years, chief dietiitan, 250-bed hospital.

DIRECTOR OF NURSES—M.S., Nursing Education; five years' teaching experience; two years, associate professor of education, collegiate school; three years, assistant director of nursing, 500-bed hospital.

MEDICAL BUREAU—*Continued*

PATHOLOGIST—Diplomate American Board; FCAP; four years, department of pathology, university medical school; seven years, director, pathology, 375-bed hospital and associate professor, pathology, university medical school.

RADIOLOGIST—Diplomate, Diagnostic Radiology, Therapeutic Radiology, Radium Therapy; past several years, radiologist, fairly large group; teaching and research, cancer, experience.

WOODWARD MEDICAL PERSONNEL BUREAU
(Formerly Aznoe's)
Ann Woodward, Director
185 North Wabash Avenue
Chicago 1, Illinois

ADMINISTRATOR—Lay; FACHA; university graduate; excellent accounting experience in business; 4 years', administrator 350-bed hospital; 4 years', administrator 400-bed general hospital; interested hospitals, 300 beds up; immediately available.

ADMINISTRATOR—Medical; FACHA; university graduate; experience includes about 7 years', administrator large teaching hospital; has taken leading part in local and national hospital affairs; immediately available; early forties.

RADIOLOGIST—Certified in diagnostic and therapeutic; experience includes several years', private general practice and 5 years', assistant instructor, radiology, university hospitals; late thirties; immediately available.

PATHOLOGIST—Certified in both branches; well trained; experience includes about 5 years', instructor, pathology, eastern medical school; several years', medical officer, director of laboratories 2 large eastern hospitals; immediately available.

ANESTHESIOLOGIST — Certified; early thirties; several years', chief, department of anesthesiology, United States Army hospital; 1 year, anesthesiologist, university hospital; past 3 years', associate, private practice of anesthesiology; immediately available.

REGISTERED CHIEF DIETITIAN—About 12 years' experience in several large hospitals; past 7 years', chief dietitian, eastern university hospital; interested only in large hospitals; prefers east; middle forties; asking $5,000.

MEDICAL RECORD LIBRARIAN—Registered; beautifully qualified with 4 year, MRL, 450-bed general hospital; past several years, MRL, 350-bed hospital; early thirties; single.

POSITIONS OPEN

ANESTHETIST—Nurse; member AANA; for 125-bed general hospital, to expand department to include school of anesthesia; must be willing to teach and supervise; three anesthetists now employed; desirable working conditions; $300 per month plus complete maintenance; city population 35,000, 20 miles south of state capital. Apply, Mr. K. S. Meredith, Assistant Administrator, Petersburg Hospital, Incorporated, Petersburg, Virginia.

ANESTHETIST—For modern 250-bed general hospital; no maternity; starting salary $325; increase semi-annually; two meals and laundry. Apply Superintendent, Sutter Hospital, Sacramento, California.

ANESTHETIST—Nurse; for 300-bed hospital; four anesthetists now on service; salary open. Apply, D. W. Hartman, Superintendent, The Williamsport Hospital, Williamsport, Pennsylvania.

ANESTHETIST—Nurse; for small, 35-bed, community hospital with cheerful and friendly atmosphere; fully accredited active member of the AHA; percentage arrangement with guaranteed minimum $400. Apply, Superintendent, Edgerton Memorial Hospital, Edgerton, Wisconsin.

ANESTHETIST—Nurse; for tuberculosis sanatorium, Seward, Alaska; salary open, depending upon experience; 40-hour week; 2 weeks' vacation and 2 weeks' sick leave; transportation between Seward and Seattle paid after one year; state training and experience. Write Administrator, Seward Sanatorium, Seward, Alaska.

ANESTHETIST — Nurse; 100-bed hospital, southern city of 125,000; salary $300 per month plus full maintenance; extra pay for night calls on case basis. Apply, Administrator, Highland Hospital, Shreveport, Louisiana.

ANESTHETIST—For 60-bed general hospital; two anesthetists employed; salary $300 per month plus maintenance. Apply, Baker Memorial Sanatorium, Colonial Lake, Charleston 6, South Carolina.

ANESTHETISTS—Nurse; 225-bed general hospital; salary open. St. Joseph Hospital, Lorain, Ohio.

ANESTHETISTS—Nurse; several; immediate vacancies; salary $250-$350 monthly; full maintenance optional; vacation, sick leave, hospitalization, etc.; 375-bed general hospital. Apply, W. S. Kohlhaas, Superintendent, Harrisburg Hospital, Harrisburg, Pennsylvania.

DIETITIAN—For 100-bed hospital; salary depends on experience and qualifications; for particulars apply Superintendent, Soldiers' Memorial Hospital, Campbellton, New Brunswick.

DIETITIAN—Registered; wanted for a fully approved 150-bed hospital; good salary and pleasant surroundings. Apply Mother Marie, Maryview Hospital, Portsmouth, Virginia.

DIETITIAN—Therapeutic; 300-bed approved general hospital, in central Pennsylvania. Apply, D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

DIETITIAN—Therapeutic; for 150-bed general hospital and to help plan new 200-bed hospital, see November "Hospitals" magazine; liberal personnel policies. Write, Miss Mildred Schlafer, Glenville Hospital, 701 Parkwood Drive, Cleveland, Ohio

DIRECTOR OF NURSING SERVICE—Assistant; for 112-bed general hospital; salary for 40-hour week, $65 per week with regular increases; vacation with pay, 5 days after 6 months, 2 weeks after 1 year; sick leave, one day for each month after 6 months and accumulative to 30 days; six holidays per year; Indiana registration necessary; residence facilities if desired at $5 per week. For further information write, Director of Nursing Service, Elkhart General Hospital, Elkhart, Indiana.

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(Continued on page 194)

Want Advertisements

POSITIONS OPEN

DIRECTOR—School of nursing and nursing service; 127-bed eastern hospital; salary open; maintenance included. MO 7, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ENGINEER—Hospital; experienced; as chief of maintenance for new 200-bed general hospital now under construction. Reply stating salary required, experience, qualifications, when available, etc., to Mr. John M. King, Administrator, Petersburg Hospital, Petersburg, Virginia.

HOUSEKEEPER—Assistant; for 650-bed hospital near San Francisco; three year supervisory housekeeping required; 40-hours; liberal vacation, sick leave and holiday provisions; salary $258; state duties and bed capacity. MO 8, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR—Clinical; for hospital school of nursing; 100-bed hospital with 40-bed addition within a year; appointment any time before January 15, 1951; Baccalaureate Degree with advanced educational courses and experience in medical and surgical nursing; salary open. Apply, Director of Nurses, Lancaster-Fairfield Hospital, Lancaster, Ohio.

INSTRUCTOR—Science; salary governed by interview and reference. Apply, Lucy R. Stillman, R.N., Director of Nursing, The Pottsville Hospital, Pottsville, Pennsylvania.

INSTRUCTORS—Clinical; 2; medical and surgical for 325-bed general hospital; degree and experience preferred. Apply, Director, School of Nursing, The Toledo Hospital, Toledo, Ohio.

INSTRUCTRESSES—Qualified; for training school for nurses; general duty graduate nurses and dietitian required for a modern 100-bed hospital in a central Manitoba town of 6,000 population; 8-hour duty, one month's vacation after one year's employment; Blue Cross Plan available; good salary with full maintenance. Apply, stating qualificaitons, experience and salary expected to the Superintendent, Dauphin General Hospital, Dauphin, Manitoba.

LIBRARIAN—Record; 300-bed approved general hospital, in central Pennsylvania. Apply D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

LIBRARIAN—Medical record; experienced; as assistant in 300-bed fully approved county hospital; must have knowledge of standard nomenclature of diseases and operations. Write, Director, Maumee Valley Hospital, Toledo 9, Ohio.

LIBRARIAN—Record; registered with A.A.M.-R.L.; to take charge of department in 135-bed hospital which will expand to 175 beds next year; well established department; hospital approved ACS and AMA. Blessing Hospital, 1000 Spring Street, Quincy, Illinois.

LIBRARIAN—Record, assistant registered and graduate of approved school; in school for medical record librarians; staff of six in department; middle west; salary open. MO 9, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

(Continued on page 196)

MISCELLANEOUS—Anesthetist and experienced Laboratory technician; immediately; highest salary and pleasant working conditions with most modern equipment. Applicants apply, Mrs. Bennett, Superintendent, The Lynn Hospital, 2940 South Fort Street, Detroit 25, Michigan.

MISCELLANEOUS—One Supervisor and one General duty nurse; meals while on duty and laundry of uniforms. Apply Business Manager, Floyd County Co-Operative Hospital; Lockney, Texas.

MISCELLANEOUS — Assistant director of nurses for a general hospital school of nursing; B.S. in Nursing Education required; also Clinical instructor in medical and surgical nursing; B.S. in Nursing Education essential; salary commensurate with education and experience. Apply, Director of Nurses, Newport Hospital, Newport, Rhode Island.

MISCELLANEOUS—Nursing director; $250-$300; immediately; Nurse anesthetist; $250-$300; Operating room supervisor; $200-$225; maintenance also; new 52-bed, 16 bassinet hospital in Manning, South Carolina; population 3,000; hour's drive to Myrtle Beach or Columbia. Apply, Administrator, Clarendon Memorial Hospital, Manning, South Carolina.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

Want Advertisements

POSITIONS OPEN

NURSE—Suture: $250 per month plus full maintenance; no night calls; western Pennsylvania college town. MO 98, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSES—General duty; for 360-bed general hospital; starting salary $175 per month with maintenance; $200 per month with partial maintenance; rotating shifts; two weeks' vacation; 30 days' sick leave; 6 holidays yearly with pay; 44-hour week; college courses available through night classes at local university. Apply Director of Nursing, Greenville General Hospital, Greenville, South Carolina.

NURSES—Registered; for general medical, surgical and obstetrical services; also supervisory nurses in 86-bed hospital. For more information write the Director of Nurses, East Side General Hospital, 2199 Cadillac Boulevard, Detroit 14, Michigan.

NURSES—General duty; salary, $210 base pay; $10 bonus evenings and nights; 40-hour week; six holidays; regular salary increases; housing and meals available at low cost. Apply Director of Nurses, Good Samaritan Hospital, Portland 10, Oregon.

NURSES—General duty; openings available; opportunities for specialization; 40-hour week; salary $220-$260; housing available for a limited period. Apply, Director of Nursing, Presbyterian Hospital, 622 West 168th Street, New York, New York.

NURSES—General duty; for 147-bed hospital; salary $215 per month with $10 differential for evening or night duty. Apply, Mrs. Ruth Garland, R. N., Superintendent of Nurses, Memorial Hospital of Natrona County, Casper, Wyoming.

NURSES—Graduate staff; for Saint Luke's Episcopal sponsored 280-bed general hospital; salary $210 to $280 per month; increases after 6 months, 12 months, 24 months, and 36 months; $10 per month above scale for evening duty and permanent night duty; excellent working conditions; staffing to produce more than 3.5 hours of nursing care per patient in 24 hours; opportunities available for study at University of Denver and University of Colorado; six holidays per year; vacation and sick leave after first year; hospital within walking distance of business district, and Denver; close to winter sports areas. Apply, Director of Nursing Service, Saint Luke's Hospital, Denver, Colorado.

NURSES—Gentral duty; for 220-bed general hospital. For further particulars write to, Miss M. E. Jackson, R. N., Superintendent of Nurses, Brandon, Manitoba.

NURSES—General staff; for 116-bed general hospital; 5-day, 40-hour week, no split hours; salary $195 per month with additional $15 for afternoon duty and $10 for night duty; raise after 6, 18 and 30 months of service; one day per month sick leave, accumulative to 24 days; two weeks' vacation after one year. Write, Superintendent of Nurses, St. Luke's Hospital, St. Paul, Minnesota.

NURSES—Obstetric; for California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $235 per month if applicant has advanced preparation or experience; $10 additional for evening and night hours; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Registered or graduate; 350-bed hospital; $200 per month plus meals; uniforms furnished; 2 weeks' paid vacation, pension and insurance plan; 8-hour day, 6 day week; night duty $225 per month. Apply, Superintendent of Nurses, McCleary Clinic and Hospital, Excelsior Springs, Missouri.

NURSES—Registered; supervisors and general floor duty; all services; positions in new 152-bed modern general hospital; straight eight-hour day, 44-hour week; six paid holidays, sick leave and three weeks' paid vacation annually; salary open. Apply Director of Nurses, Presbyterian Hospital, Waterloo, Iowa.

NURSES—Staff; for a 112-bed general hospital; salary for 40-hour week, $53.20 per week with regular increases after six months; 1½ years, and 3 years; $2.50 bonus per week for evening and night duty; vacation with pay, 5 days after six months, 2 weeks after 1 year; sick leave one day for each month after 6 months and accumulative to 30 days; six holidays per year; Indiana registration necessary; residence facilities if desired at $5 per week. For further information write, Director of Nursing Service, Elkhart General Hospital, Elkhart, Indiana.

(Continued on page 198)

Want Advertisements

POSITIONS OPEN

NURSES—Staff: for 600-bed modern tuberculosis hospital with university affiliation; excellent salary; 44-hour week; 28 days vacation; 15 work-days sick leave per year, cumulative to 90 days; retirement plan; modern nurses' home with all private rooms; excellent food; laundry furnished. For additional information write or wire, Director of Nursing Service, Durham Hospital, Cincinnati 5, Ohio.

SUPERVISOR—Operating room: for 66-bed general hospital; satisfactory experience and/or advanced preparation desired; but not required; basic salary, $200 plus complete maintenance; automatic increases; 44-hour week; three weeks' vacation after first year; four weeks' thereafter. Apply to Superintendent, Washington County Hospital, Washington, Iowa.

NURSES—Surgical and general duty; salary $217 per month, full maintenance; higher salary for surgery; increase in three months and six months; two days off per week. Oakland County Tuberculosis Sanatorium, Pontiac 11, Michigan.

TECHNICIAN—X-ray and laboratory combined; salary $250 with complete maintenance. Apply, Superintendent, State Sanatorium, Basin, Wyoming.

TECHNICIAN—Laboratory; for 95-bed hospital; salary, $300; maintenance available; 41½-hour week; travel expense refunded at end of 18 months of service. Apply, Wilcox Memorial Hospital, Lihue, Kauai, T.H.

TECHNICIAN — Laboratory; well qualified young lady to assume full charge of small, modern laboratory; college town; excellent starting salary, plus full maintenance. Apply Administrator, Centre County Hospital, Bellefonte, Pennsylvania.

THE MEDICAL BUREAU
Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATORS — (a) General; 250-bed hospital; town of 100,000, eastern seaboard. (b) Medical; outstanding lay administrator eligible; voluntary hospital, 400 beds; university medical center; east. (c) Assistant medical director; university group of hospitals; opportunity for obtaining excellent experience various phases of administration. (d) Voluntary hospital, 275 beds under reorganization; minimum five years' administrative experience required; university town, midwest. (e) New hospital recently opened for operation, 150 beds, general; southwest. (f) Lay; 100-bed hospital operated by well established group; expansion program; building experience desirable. (g) Community owned hospital, small size; southern California. (h) Lay; pediatric unit of university group; $10,000-$15,000. (i) General, 150 beds; New England. (j) Medical executive secretaryship; state

(Continued on page 200)

MEDICAL BUREAU—*Continued*

medical society. (k) Assistant qualified to assist materially in expansion program increasing present capacity of 350 beds to 500; large city, educational center; midwest. (l) Assistant; large teaching hospital; physician or lay; formal training preferred; east. MH1-1.

ADMINISTRATORS—NURSES. (a) General hospital, 90 beds; town of 20,000, southwest. (b) General hospital, 125 beds; degree preferred; college town, east. (c) Home for aged, capacity 140; 40 employees; $5,000-$6,000; midwest. (d) Assistant; administrative training and experience required; 125-bed general hospital; $4,000-$5,000; town 80,000 near university center, midwest. MH1-2.

ANESTHETISTS—(a) To join staff of group of physicians specializing in anesthesiology. (b) General hospital, 500 beds; medical anesthesiologist in charge; $4200, maintenance; east. (c) To join staff of ten-man group; college town of 20,000, southwest. (d) Small general hospital operated by American Company in Arabia; substantial salary, maintenance, transportation. MH1-3.

DIETITIANS—(a) Chief; new hospital, 300 beds, unit university group; faculty rank. (b) To take charge department, new hospital, small size; southern California. (c) Chief; hospital operated by 15-man clinic; residential town; east. (d) Therapeutic and teaching dietitian; important hospital; southern California. (e) Assistant chief; duties consist of supervising staff of twenty; 400-bed hospital; college town, midwest. (f) Assistant chief; one of leading hospitals, Chicago area. MH1-4.

Want Advertisements

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSES—(a) General 350-bed hospital; 125 students; university affiliation; five-year nursing course; university medical center; midwest. (b) Large teaching hospital; collegiate program; university city, east; $6000. (c) Director nursing service; 750-bed hospital, general; midwestern metropolis. (d) Director for school conducted by junior college; competent organizer required; Pacific Coast. (e) Director to serve as educational advisor; duties consist of examining schools throughout state; considerable travel. (f) New hospital, 175 beds; no school; excellent staff; town of 20,000, resort area, Pacific Northwest. (g) New tuberculosis hospital, 300 beds; unit of university group; university center, midwest. (h) Director, nursing service; new hospital; fashionable winter resort city, south. MH1-5.

EXECUTIVE HOUSEKEEPERS—(a) New hospital, small size; completely air-conditioned; town 35,000, Texas. (b) New hospital 300 beds; unit university group; minimum $3600; university center; midwest. MH1-6.

EXECUTIVE PERSONNEL—(a) Director of plant service; teaching hospital of over thousand beds. (b) Office manager; 150-bed hospital increasing to 225; east. (c) Purchasing agent; large hospital outside Continental United States. (d) Purchasing agent qualified to assume control of centralized purchasing department; fairly large hospital, Pacific Coast.

MEDICAL BUREAU—*Continued*

(e) Comptroller; advantageous if qualified purchasing; 175-bed general hospital affiliated with 15-man clinic; southwest. MH1-7.

FACULTY APPOINTMENTS—(a) Director of education; important pediatric hospital, university group; minimum $4500. (b) Nursing arts instructor; program recently established by university; capable organizer required; $4000-$5000. MH1-8.

LIBRARIANS—(a) To direct complete medical library, teaching hospital; west. (b) Patients' library; 225-bed hospital; New England. MH1-9.

MEDICAL RECORD LIBRARIANS—(a) Chief; capable of complete departmental reorganization; 500-bed hospital affiliated university medical school; east. (b) Chief; fairly large hospital, medical school affiliations; near Chicago. (c) New hospital, Texas. (d) Chief; large teaching hospital; department staff of 32; around $4200; Pacific Coast. MH1-10.

PHARMACISTS—(a) Large general hospital; metropolis, United States dependency. (b) Well established group; Chicago area. MH1-11.

TECHNOLOGISTS—(a) Chief; fairly large hospital; $4200, Chicago area. (b) Tissue; university medical school; east. (c) X-ray technician; office of certified radiologist; university medical center; west. (d) Laboratory; well established group; winter resort town, California. (e) Electroencephalography technician; 250-bed teaching hospital; university medical center; west. (f) Chief; 300-bed hospital; vicinity, New York City. MH1-13.

(Continued on page 202)

MEDICAL BUREAU—*Continued*

SUPERVISORS—(a) Operating room; 300-bed general hospital affiliated with one of country's leading clinics; new clinic building recently dedicated; staff of outstanding specialists; east. (b) Outpatient clinic, average 3000 patients monthly; California. (c) Night; modern hospital operated under American auspices, Asia. (d) Psychiatric; newly created department in new wing of well established hospital; department averages 36 patients, principally private; college town, 100,000; midwest. (e) Obstetrical; teaching hospital; southern town of 30,000, $300 maintenance. MH1-12.

WOODWARD MEDICAL PERSONNEL BUREAU
(Formerly Aznoe's)
Ann Woodward, Director
185 North Wabash Avenue
Chicago 1, Illinois

ADMINISTRATORS—Lay: (a) 500-bed general hospital; very desirable locality; about $15,000. (b) Lay; 300 beds; general hospital; university city, 125,000; requires member or fellow, ACHA; $12-$15,000. (c) Lay; 240-bed general under construction; attractive university, winter resort city; southwest. (d) Lay; requires member, ACHA; 300-bed general hospital; very cooperative Board; south. (e) Medical; 250-bed general and tuberculosis hospital; part of western medical center; fully furnished 2 bedroom home. (f) Excellent general hospital of fairly large size; must have

Want Advertisements

POSITIONS OPEN

WOODWARD—*Continued*

at least 8 years' experience in hospitals 150-200 beds. (g) Lay; 150-bed general hospital; primarily railway company patients; excellent southern residential town, 25,000. (h) Lay; old established, 16 man group-clinic; all specialties represented; university and college city, 50,000; substantial salary. (i) Lay; highly regarded, old established group with excellent 50-bed hospital; desirable resort town near Chicago; $10-$12,000 plus 10% year end bonus. (j) Lay; assistant; general hospital; medium size; requires graduate in hospital administration or previous experience; Maryland. (k) Lay; 80-bed general voluntary hospital; good plant; complete charge; serves large area in Yellowstone Park region. (l) Medical; Canadian hospital now enlarging to accommodate 150 patients; substantial salary; large tourist city. (m) Medical; general hospital; 300 beds; duties chiefly administrative; prefer physician with hospital experience; west coast. (n) Medical; for established 5 man group with excellent hospital; will be chief of staff; Texas town, 10,000; about $10,-000. (o) Physician with extensive administrative experience to become executive officer of eastern medical society; very substantial salary. (p) Medical; assistant; large southern university hospital; Masters in Hospital Administration desirable; $8-$9000. (q) Medical; to direct medical activities, teach staff and personnel; large midwest mental hospital. (r)

WOODWARD—*Continued*

Medical director and superintendent; to replace incumbent, retiring account illness; large tuberculosis hospital; city 250,000; $8,500 minimum, furnished home; full maintenance. (s) Lay; New Mexico general hospital newly opened of smaller size. (t) Lay; wealthy eastern community 10,000 ready to erect general hospital; excellent opportunity for experienced man to build his own plant. (u) Lay; assistant; preferably clergyman; 100-bed general; excellent nurses school; cooperative, strong board; large university metropolis; northeast central. (v) Lay; assistant; complete charge business office and accounting; 250-bed general hospital; college city 70,000; Ohio. (w) Lay; requires Masters in Hospital Administration; new county hospital of fairly large size; will seek immediate approvals; south. (x) Lay; West Virginia general hospital of medium size; elevation 3,000 feet; excellent climate; prefer southerner; town 25,000. (y) Lay; medium size California general hospital; wonderful climate year round; town 15,000. (z) Lay; assistant; 200-bed general hospital; college city 35,000; woman considered; northeast. (aa) Lay; smaller general voluntary hospital adding 25 beds; pleasant town near Chicago. (bb) Lay; 75-bed new general hospital; graduate nurses staff; southwest town 14,000; consider woman.

ADMINISTRATORS—NURSE. (a) New small general hosiptal; New Mexico. (b) New 40-bed general hospital; attractive residential town near large university medical center; central. (c) Present superintendent leaving after 9 years; matrimony; excellent 65-bed

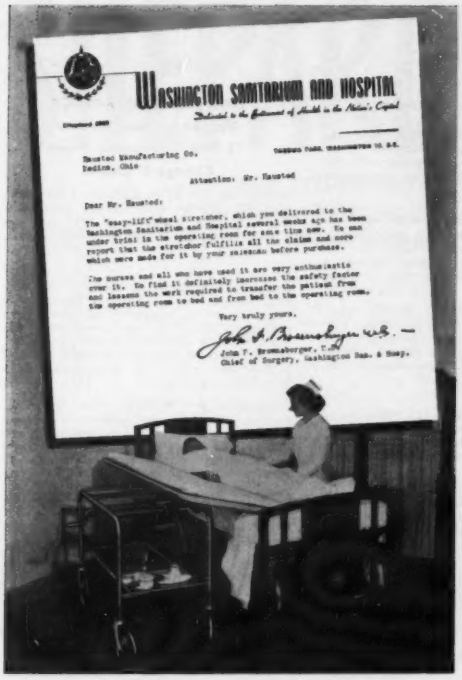
(Continued on page 204)

WOODWARD—*Continued*

general hospital; city 25,000; Texas. (d) Small general hospital opening soon; will have excellent facilities; Georgia. (e) 32-bed general county hospital; cooperative group of doctors; nice nursing staff; central. (f) Small Iowa general hospital situated in lovely residential town near large city. (g) Excellent hospital of medium size; requires good Lutheran; attractive midwest town. (h) 75-bed general hospital; doctors and all graduate nursing staff; recently opened; desirable town 15,000; consider woman lay administrator.

ADMINISTRATIVE—STAFF APPOINTMENTS. (a) Credit manager; small Arkansas general hospital and health center; must know accounts receivable; town 10,000; substantial salary. (b) Purchasing agent; large southern California hospital; much sought after town 40,000; annual purchases exceed $200,000; good starting salary. (c) Business manager; small Florida general hospital just opening. (d) Office manager; experienced; large Chicago hospital; requires accounting background. (e) Business manager; general hospital; 50 beds; exceptionally well equipped; residential Illinois town adjacent several large cities. (f) Chief accountant; 300-bed general hospital; medical school affiliations; Lake Erie university city. (g) Accountant to head department, 300-bed general hospital; capable installing cost and budget systems; Pennsylvania; opening January.

ANESTHETISTS—(a) Medium sized approved hospital vicinity Philadelphia; $4,800. (b) Seven man clinic operating small approved hospital; southern Michigan; $4,800 up.



THE HAUSTED WHEEL STRETCHER

"Increases the Safety Factor and Lessens the Work Required!"

In the letter above, Dr. Brownsberger, Chief of Surgery at the Washington Sanitarium and Hospital, says that the Hausted "Easy Lift" Wheel Stretcher "fulfills all the claims and more." The Hausted Stretcher requires only one nurse to care for even the heaviest patient. By turning just one control the patient is transferred from stretcher to bed, quickly, easily and safely. As the top tilts, it recesses into the mattress of the bed. This provides a "locking action" that prevents all movement of the stretcher during the patient transfer.

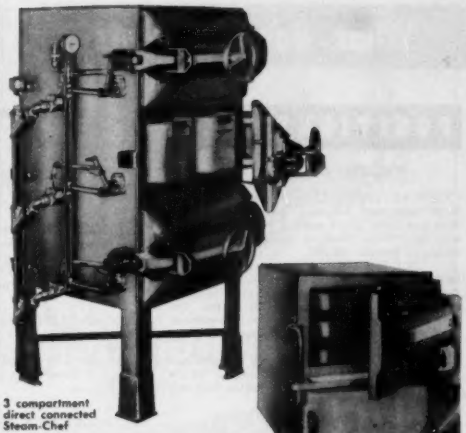
The "Easy Lift" stretcher combines the features of several old type units. No longer need hospitals buy several pieces of equipment to transfer patients.

WRITE FOR DESCRIPTIVE LITERATURE AND PRICES

PAT. APPLIED FOR

HAUSTED Easy Lift WHEEL STRETCHERS

HAUSTED
MANUFACTURING COMPANY
MEDINA, OHIO



3 compartment direct connected Steam-Chef

Steamcraft Cub for counter. Also available with 2 compartments, with or without base.

Have a New Look at Your Kitchen!

Maybe you are already doing everything possible to make *your* kitchen operating efficiency top-notch. But if you are not using a steam cooker, the chances are 10 to 1 it's dead easy for us to show you how to save time, labor, fuel, space, food and money.

It's simple as A B C for a big kitchen or a little kitchen to effect BIG savings with a Steam-Chef or a Steamcraft. You release your range top for other purposes, you cut down on pots and pans and cleaning work. You turn out the food as needed, and serve it freshly cooked. You reduce shrinkage and steam table storage. You get along with less help. Expenses are down, profits are up.

These steamers embody the concentrated results of many years' development by the ONLY exclusive specialists in the steam cooker business. Let us tell you more.

Steam-Chefs are made in several sizes, for direct steam, gas or electric operation. Steamcrafts, our junior size steamers, are run by gas or electricity, or direct steam. Full details from your supply house or us.

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3333 LAKESIDE AVE. CLEVELAND 14, OHIO

For BETTER Steaming—
STEAM-CHEF

Want Advertisements

POSITIONS OPEN

WOODWARD—*Continued*

CLINICAL INSTRUCTORS—(a) Pediatrics; large approved hospital, attractive location Michigan lake resort region; $3,600. (b) Obstetrics; 300-bed teaching hospital; city 75,000 adjacent Detroit; $3,900.

DIETITIANS—(a) Large approved hospital, rapid extension program, southern medical center; $4,200 maintenance. (b) Large, approved psychiatric hospital vicinity midwest state capital and educational center; $4,000.

DIRECTOR OF NURSES—(a) Seventy-bed approved hospital southern Michigan; $4,200 yearly. (b) 200-bed approved Florida hospital, eastern resort area; $4,800.

DIRECTOR OF NURSES ASSISTANTS—(a) 300-bed eastern hospital in process of expanding to 500 beds; Philadelphia area; $3,000 up. (b) 200-bed approved hospital vicinity Daytona Beach, Florida.

EDUCATIONAL DIRECTORS—(a) 150-bed approved hospital; excellent educational program; noted Florida resort; $3,600 up. (b) 150-bed accredited hospital Texas educational and medical center; $4,200.

EXECUTIVE HOUSEKEEPER—Experienced; able assume responsibility for staff of 150, large university hospital excellent midwest location; minimum $4,200.

WOODWARD—*Continued*

MEDICAL SOCIAL WORKER—Interesting followup work for cancer diagnostic clinic serving sixty mile radius, southern Illinois; salary open; will consider nurse with public health experience.

NURSING ARTS INSTRUCTORS—(a) 175-bed Massachusetts hospital with ultra modern building under construction; $3,600 up. (b) 150-bed Florida hospital; excellent educational program; $2,700 maintenance.

RECORD LIBRARIANS—(a) Medium sized general hospital now under construction; gulf resort city 30,000; position available early 1951. (b) New, well staffed 150-bed Florida hospital; progressive community adjacent Gulf of Mexico.

SCIENCE INSTRUCTORS—(a) 150-bed approved hospital; southeastern state capital and university town; $3,000, maintenance. (b) 200-bed hospital nursing college, California university town; $3,600.

SUPERVISORS—(a) Pediatric; 300-bed New York teaching hospital; $3,000 up. (b) Night; small, new, general hospital; city 10,000 adjacent Texas capital; $3,000, maintenance.

SURGICAL SUPERVISORS—(a) 200-bed hospital with Columbia university affiliation; $3,600 up; south. (b) 300-bed hospital college affiliation, southeastern Pennsylvania; $3,400 up.

(Continued on page 206)

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

DIRECTOR OF PURCHASING AND PERSONNEL—Middle west; 60-bed psychiatric treatment clinic established in 1898, fully approved; beautifully located in residential section in city of 450,000; $3600 minimum to start.

DIRECTOR OF NURSES—East; 153-bed hospital, fully accredited; school of nursing with enrollment of 61 students; head nurses and supervisors are efficient and cooperative, having been with hospital for some years; salary will depend upon qualifications but will be good and include full maintenance and a very lovely apartment.

DIRECTOR OF NURSES—New school of nursing of well known middle western university; nursing school is on a university level and program is an expanding one; this is a wonderful opportunity and salary will be good, including full maintenance.

NURSE ANESTHETIST—East; 154-bed hospital in city of 35,000, fully approved; have nurses training school; $4800 plus full maintenance.

NURSING ARTS INSTRUCTOR—Middle west; 112-bed hospital located in pleasant residential section of large city, only ten minutes from downtown; B.S. Degree in Nursing Education; hospital fully approved; $5400 plus full maintenance.

Want Advertisements

POSITIONS OPEN

SHAY—*Continued*

CHIEF DIETITIAN—Southwest; 85-bed hospital located in modern, progressive town of 11,000; department is well staffed and has all new, modern equipment; $4200.

DIETITIAN—East; 125-bed hospital beautifully located in resort area; hospital fully approved and is affiliated with well known university; $3600 plus full maintenance.

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gault, R.N., Director
4707 Springfield Avenue
Philadelphia 43, Pennsylvania

ANESTHETISTS—(a) New 200-bed hospital, opening April 1st. (b) 100-bed; Illinois; $450, plus laundry; 44-hour week.

DIRECTORS OF NURSING—(a) 100-bed hospital; graduate staff; starting, $325, maintenance. (b) 100-bed psychiatric hospital; P.G. work and some teaching required; $4,800, plus maintenance.

DIETITIAN—130-bed; New York; $3,000, maintenance; 44-hour week.

EDUCATIONAL DIRECTOR—Florida; $3,000; maintenance includes apartment.

MEDICAL PERSONNEL EXCHANGE —*Continued*

SUPERVISORS—(a) Surgery; small hospital; winter resort; $2,400 plus maintenance. (b) Central supply room; $200, plus meals and laundry.

RECORD LIBRARIAN—Chief; 450-bed general hospital; east; salary open.

PSYCHOLOGISTS—Male or female; (a) Diagnostic center; east; Ph.D. required; salary open. (b) Small mental hospital; $4,500; M.A. accept.

EXECUTIVE HOUSEKEEPER—Large, well staffed eastern hospital; position requires person with good educational background and experience.

LAUNDRY MANAGER—300-bed general hospital; east; salary commensurate with ability.
No charge for registration

BUSINESS AND MEDICAL REGISTRY
(Agency)
Elsie Miller, Director
553 South Western Avenue
Los Angeles 5, California

DIRECTOR OF NURSES—Private general hospital of 75 beds, old California town in the orange country, 50 miles from Los Angeles; $300, maintenance; 40-hour week.

(Continued on page 208)

BUSINESS AND MEDICAL REGISTRY—*Continued*

ADMINISTRATOR AND DIRECTOR OF NURSES—Small district hospital opening in February; scenic area northwest of Reno; $350; aptitude more essential than experience.

ANESTHETIST—Oregon hospital of 75 beds; two anesthetists on duty; average two majors, two minors daily; 25 deliveries monthly; congenial staff; call adjusted; $350.

ASSISTANT DIETITIAN — Private general 185-bed hospital south of San Francisco; $230, meals; 40-hour week.

SURGERY NURSE—Western mining company hospital; 25 beds; needs additional surgery nurse with good experience and/or post course; $330 with complete maintenance; 48-hour week.

PLACEMENT BUREAUS

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If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director.

We Do Not Charge a Registration Fee.

Want Advertisements

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Many Good Positions in All Medical Specialties

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We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

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We have good opportunities in Michigan and the mid-west for medical personnel in all fields. Our service is confidential and carefully supervised by Esther Allen, Owner.

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(Continued on page 210)

FOR SALE

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

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NURSING AND MEDICINE

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

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Want Advertisements

SCHOOLS—SPECIAL INSTRUCTION

PETERSBURG HOSPITAL SCHOOL OF ANESTHESIA, Petersburg, Virginia, offers a comprehensive program of study of 12 months in Anesthesia to graduates of accredited schools of nursing. All Anesthetic Agents and modern techniques are taught. This course meets the requirements of the American Association of Nurse Anesthetists. For further information address, Mr. Louis M. Rothman, R. N., Department of Anesthesia, Petersburg Hospital, Incorporated.

JERSEY CITY MEDICAL CENTER SCHOOL OF NURSING offers to qualified graduate nurses a four-month course in operating room technic. Full maintenance and stipend granted. Apply to Director of Nurses, Jersey City Medical Center, Jersey City, N. J.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of $60 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

SCHOOLS—SPECIAL INSTRUCTION

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

WASHINGTON UNIVERSITY SCHOOL OF NURSING OFFERS the following Courses and Programs for the year 1950-51:

Programs leading to the degree, Bachelor of Science in Nursing:
- Advanced Psychiatric Nursing
- Community Health Nursing
- Supervision of Nursing Service
- Teaching in Schools of Nursing
- Ward Administration and Teaching

Special Advanced Professional Courses:
- Advanced Psychiatric Nursing (twelve months)
- Advanced Clinical Practice in Operating Room Technique (four months)

For further information write to the Director, Washington University School of Nursing, 416 South Kingshighway, St. Louis 10, Missouri.

The MARGARET HAGUE MATERNITY HOSPITAL, The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

Four Months' Course:

Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

Six Months' Course:

Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

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TRADE MARK
x-ray-detectable
SPONGES

The X-ray-detectable monofilament in RAY-TEC Sponges always appears on the X-ray plate in an unmistakable 'string pattern' regardless of the angle from which the picture is taken. The radiologist knows what to look for, what to find; and it is easier because the RAY-TEC monofilament covers a wide area on the X-ray plate. The soft, non-abrasive monofilament is distinctive and cannot be confused with bone structure or artifacts.

Write for samples to Hospital Division—

Johnson & Johnson
NEW BRUNSWICK, N. J.

What's New for Hospitals

JANUARY 1951 Edited by BESSIE COVERT

Liter-Flow Adaptor

In case of emergency oxygen can be administered as therapy from an industrial type oxygen regulator and a cylinder of oxygen with the new Linde L-25 Oxygen Therapy Liter-Flow Adaptor. The new adaptor converts pounds per square inch pressure to liter-per-minute flow. Normally, industrial type oxygen cannot be used for therapy, even under emergency conditions, because of the regulator but with the new Liter-Flow Adaptor any oxygen can be used by the doctor, rescue crew or civilian defense organization trained in oxygen therapy.

The Liter-Flow Adaptor is approximately four inches long and is finished in brushed chrome. It contains no moving or fragile parts and should give long, trouble-free service without maintenance. It is small in size and light in weight and is therefore easily stored or carried. **The Linde Air Products Co., Dept. MH, 30 E. 42nd St., New York 17. (Key No. 1)**

Fireproof Paint Remover

A new non-inflammable paint and varnish remover is available for quick removal of paint and varnish from wood surfaces. Known as Kurl-Off, the product spreads smoothly and quickly and dissolves the finish without hurting the wood. In 10 to 15 minutes the old finish lies loose on top of the wood, ready for removal. The product contains no alkali, mineral acids, water, benzol or carbon tetrachloride and no after-rinse is required. It is non-corrosive, non-staining and safe on all wood surfaces since it cannot burn or explode. It can also be used effectively on metal. **Hillyard Chemical Co., Dept. MH, St. Joseph, Mo. (Key No. 2)**

Thermo-Safe Hot Water Bottle

A hot water bottle which is said to be completely safe and to avoid any possibility of burns is available as the Thermo-Safe. Made of sponge-rubber, the bottle is filled with steaming hot water and can be applied safely to the patient without wrapping of any kind, according to the manufacturer. It is insulated against excessive loss of heat so that both the patient and the nurse handling the bottle are protected against shock and burns. The sponge rubber diffuses the heat evenly and comfortably and prevents the Thermo-Safe bottle from slipping and sliding.

The Thermo-Safe has a simple stopper cap that does not leak and cannot be lost. It is available in beige and is easily

cleaned with soap and water. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 3)**

Plastic Infusion and Filter Sets

Safety, simplicity and sterility are claimed as advantages in using the new Cutter plastic intravenous infusion sets known as Saftiset and the all plastic and nylon filter set for blood and plasma infusions known as Saftifilter. The sets are packaged in special containers which are easily stored and are supplied sterile for immediate use. The sets offer the advantages of glass units without the breakage hazard.

The Saftifilter sets provide three separate filters in the filtering unit, thus ensuring safety in operation since clots of fibrin are removed without plugging and a constant flow of blood or plasma into the patient's vein is permitted. **Cutter Laboratories Dept. MH, Berkeley 1, Calif. (Key No. 4)**

Aroflint

A new base material for use in the manufacture of air-dry coatings for wood and composition surfaces has been developed by U. S. Industrial Chemicals, Inc. Finishes based on Aroflint will differ from conventional coatings in both chemical and physical properties. Aroflint contains no oil or nitrocellulose and can be considered a true plastic finish since it is based on a soluble type phenolic resin which dries or cures at room temperature by chemical action. Aroflint coatings will be supplied to users by various paint, varnish and lacquer producers. The product can be applied by brush, spray or dip, according to normal procedures, and the number of coats required will depend upon the type of finish and the type of surface employed. **U. S. Industrial Chemicals, Inc., Dept. MH, 60 E. 42nd St., New York 17. (Key No. 5)**

Picker Footstool

The chrome steel legs on the new Picker Footstool are set at an angle so that a patient may stand on any part or corner of the stool without danger of tipping. The rubber feet prevent slipping and the ribbed rubber top assures a firm foothold. Designed to help patients get on and off of x-ray tables, the footstool is equally practical for getting in and out of bed. The footstool is 8½ inches high with a platform area 10¼ by 14 inches. It is available with or without a side rail. The side rail model has a support extending 39¼ inches from the floor. The illustration shows the stool

with side rail with a section cut away. **Picker-Ray Corp., Dept. MH, 300 Fourth Ave., New York 10. (Key No. 6)**

Address manufacturers for further information and Prices — or use Reader's Service blank on page 222

Room Furniture

A complete new line of Shampaine Metal Hospital Bedroom Furniture is being introduced. Included is furniture for deluxe, standard and dormitory groups in a broad selection of designs and colors to meet every need. Through an arrangement with the Englander Company, Shampaine-Englander Hospital Beds and Mattresses are combined with Shampaine case-work to make up the room groups sold exclusively by Shampaine. **Shampaine Company, Dept. MH, 1920 S. Jefferson Ave., St. Louis 4, Mo. (Key No. 7)**

Aren Hospital Lotion

Aren Hospital Lotion is a non-alcoholic lubricant containing lanolin, olive oil, natural menthol, petrolatum, stearic acid, glycerine, magnesium stearate and Hexadecanal. The menthol content cools the skin without drying and the lotion has a delicate fragrance. It is designed for back and body rubs, to protect and soften the skin and to alleviate minor irritations. It is a stable emulsion which does not separate, even under freezing conditions, and it is economical to use. **Will Ross, Inc., Dept. MH, 4285 N. Port Washington Rd., Milwaukee 12, Wis. (Key No. 8)**

Electric Room Humidifier

A small, portable electric room humidifier is available in a new model introduced by Fresh'nd-Aire. Attractively designed, the new unit stands but 11 inches high and is 13 inches in diameter. It can be readily carried to the place of need and quickly plugged into any electric outlet. The humidifier is constructed of two-tone green-gray and cream plastic. **Fresh'nd-Aire Co., Dept. MH, 221 N. La Salle St., Chicago 1. (Key No. 9)**

Dry Mop Cleaner

A compact new Dry Mop Cleaner attachment for use with Spencer Portable Vacuum Cleaners as well as with the Spencer built-in Vacuum Cleaning Systems is now available. The new attachment eliminates the need for shaking of dry mops and permits their effective cleaning easily and quickly. The unit can be attached quickly by simple insertion into the inlet valve of either the portable or the built-in cleaner. The dry mop is simply passed back and forth across a flat slotted plate which forms the top of the attachment and draws the dust out. **The Spencer Turbine Co., Dept. MH, 484 New Park Ave., Hartford 6, Conn. (Key No. 10)**

Knit Patient Gown

Increased comfort is the prime feature of the new Angelica "Nittgown," knit of soft cotton fibers. Because it is made of a knit rather than a woven cotton, the gown does not require mangling or other finishing, thus reducing laundry costs. It is also lighter in weight. The gown is soft, absorbs moisture, thus making it cooler in summer and warmer

in winter, and does not bind since it stretches with the patient's motion.

The gown is designed for comfort and ease of handling in the laundry. It has roomy raglan style sleeves, two sets of tape ties which are permanently bartacked to the gown, a large breast pocket, large sleeve openings, and all seams are finished and all strain points reenforced. The gown is designed to meet United States Department of Commerce Bureau of Standards specifications. **Angelica Uniform Co., Dept. MH, 1419 Olive St., St. Louis 3, Mo. (Key No. 11)**

Guth Hangers

Hanging fluorescent fixtures can now be done by one man when using the new Guth U-D-T Hangers recently introduced. An exclusive stem attachment prevents turning, twisting or up and down movement at the ceiling. The hangers provide an adjustment for leveling up to 2¼ inches. **The Edwin F. Guth Co., Dept. MH, 2615 Washington Ave., St. Louis 3, Mo. (Key No. 12)**

Plastic Cubicle Curtains

Cubicle curtains in attractive colors in opaque plastic are now available. The curtains provide decorative possibilities while offering easy maintenance. They are washed with soft soap and warm water and need not be taken down unless desired.

The new plastic cubicle curtains are flame retardant, stain resistant and impervious to mildew. They are durable and inexpensive and are available in nile, ecru, green, white, blue, rose and yellow. **Sherman Mills, Dept. MH, 77 Bedford St., Boston 11, Mass. (Key No. 13)**

Anti-Slip Floor Finish

A new self-polishing floor finish, which is known as Whiz Check-Slip, is announced as being certified anti-slip by Underwriters' Laboratories. The polish dries to a hard lustrous finish which can be damp mopped or buffed and does not become sticky even in hot, humid weather. It is applied and cared for like wax although it is said to contain no wax. It is a plasticized resin type of continuous protective film which is easily applied and long wearing. The new finish is resistant to heat or cold, is non-inflammable since it is a water emulsion product, and is not subject to contamination. It is designed for use on all types of floors and can be quickly removed with ordinary types of floor cleaners when desired. **R. M. Hollingshead Corp., Dept. MH, 840 Cooper St., Camden 2, N. J. (Key No. 14)**

Leg Rest

Hospitals for convalescents, chronic disease cases and Veterans' Facilities should find the Little Otto useful with ambulatory patients who sit much of the time. This simple device is a portable leg and foot rest which can be used with any chair. Contoured for leg comfort, this light weight device is placed in front of the chair and gives restful comfor for patients requiring elevation of the feet. When not in use the Little

Otto is easily taken apart and packs flat. **V. Mueller & Co., Dept. MH, 408 S. Honore St., Chicago 12. (Key No. 15)**

Address manufacturers for further information and Prices — or use Reader's Service blank on page 222

Automatic Pneumatic Tube System

The "mechanical brain" principles of the dial telephone are employed in a new automatic pneumatic tube system long in use in Europe and recently introduced into this country by the International Standard Trading Corporation of New York. an associate of the International Telephone and Telegraph Corporation.

A feature of the equipment is a special selective dial in the carrier which permits the sender to forward his message or article to any other of a number of stations without the intervention of an operator or central dispatcher. Reduced floor space and personnel required result in efficiency and economy of operation.

The system is simple, yet highly flexible, and can be adapted to meet the requirements of all types of enterprises. It should be especially valuable in the hospital for the dispatching of mail, records, prescriptions and other items. Materials are dispatched speedily and with a minimum of handling and because of its automatic operation, greater privacy is ensured in the handling of important messages. The electrical part of the system is manufactured by Mix and Genest, a German subsidiary of I.T.&T., and all other items are supplied and the equipment installed by the United States distributor, **Airmatic Systems, Inc., Dept. MH, 141 Charles St., New York 14. (Key No. 16)**

Improved Beem Bed

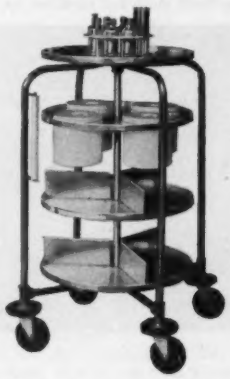
The fourth model of the Beem Bed has been improved for easier operation and more streamlined appearance. A one-half horse power motor operates a quiet, new type reciprocating pump which provides hydraulic power instead of electric power to operate the bed. The new bed has a variable height from 23 to 32 inches, thus permitting nursing height when needed and the lower height for safety when the patient is unattended. The oscillatory action of the bed is now available for any period of time, the angle being limited to an alternate 10 inch elevation of each end of the bed.

A new type tray is used on the new

model which is supported by a heavy tube on the toilet side of the bed so that it can be brought into the desired position by the patient. Push buttons for the patient are located on the front of the tray which provides storage space 2½ inches deep. Controls for the power, variable elevation and oscillator are placed on the opposite side of the tray for operation by the nurse. The new bed is furnished with a foam rubber mattress and a standard for intravenous equipment can be attached. Cut-off switches to inactivate any or all of the mechanized parts of the bed are provided. **The California Darlington Co., Beem Bed Division, Dept. MH, 11702 Mississippi Ave., Los Angeles 25, Calif. (Key No. 17)**

Revolving Shelf Utility Cart

Four spun aluminum shelves, each 22 inches in diameter, hung on a stainless steel central shaft, provide carrying space on the Lazy Susan Utility Cart No. 4. These trays revolve at a touch, giving quick access to material on the cart from

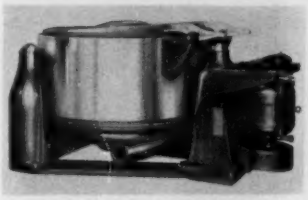


any side. Steel tubing protects the circular shelves and serves as propelling handles. At the bottom of each tube is a five inch rubber tired, pivoted caster for easy propulsion in any direction. The cart is 43 inches high and can be used for carrying medications, dressings and supplies of various types. **Gennett and Sons, Inc., Dept. MH, Richmond, Ind. (Key No. 18)**

Improved Shade Rollers

The Lifetime, Lubricated Bearing is a new development in Hartshorn window shade rollers which permits practically noiseless operation, smoother action and increases the life of the rollers. The firm, smooth-running bearing surfaces spin quietly with a minimum of frictional loss and protect the shade cloth, thus assuring longer shade life. **Stewart Hartshorn Co., Dept. MH, 250 Fifth Ave., New York 1. (Key No. 19)**

Notrux Extractor



An independently mounted motor for smooth, quiet operation is a feature of the improved Notrux Extractor. The motor is mounted on a bracket supported entirely by the rear Meehanite Metal Suspension Column of the extractor, thus relieving the curb of any unbalanced weight. The motor bracket pivots in bearings bolted to arms extending from the rear suspension column. Swinging action of the motor bracket absorbs vibration of the motor and contributes to the smooth performance. **The American Laundry Machinery Co., Dept. MH, Cincinnati 12, Ohio. (Key No. 20)**

Aluminum Mouldings

Marsh Color-Matched Aluminum Mouldings have been introduced to match every Marlite panel color for all interiors. The mouldings are available for inside corner, outside corner, division, tub mouldings or edging, edging and cove. The color range includes yellow, cream or eggshell, blue, coral or suntan, green, white, persian red, pearl gray, royal blue, black and maroon to match or harmonize with Marlite panels. All mouldings are available in 8 foot lengths and feature deep channels and wide flanges, and they are easy to cut and fit. The color is supplied by the Marlite baked plastic finish. **Marsh Wall Products, Inc., Dept. MH, Dover, Ohio. (Key No. 21)**

Pillow Radio

A new model Telex Pillow Radio is now available for hospital use. The compact unit is made to be attached to the head of the bed where an upside-down dial permits easy tuning by the patient. The unbreakable under-pillow speaker is so constructed that it can be easily sterilized and it provides clear radio reception. A glareless reading lamp is built into the radio so that the unit serves a double purpose.

The radio is designed for coin-operation, thus making it a source of income to the hospital while providing patients with individual radio reception which is heard only by the patient desiring it. **Telex, Inc., Dept. MH, Telex Park, St. Paul 1, Minn. (Key No. 22)**

Address manufacturers for further information and Prices — or use Reader's Service blank on page 222

Film Drier

The new Aridair Drier is a new type film drier designed for the small x-ray department. It is lower in cost than the earlier model, less subject to rusting, quieter in operation, faster drying and improved in design and appearance. Under normal conditions, using no wetner or pre-drying, the Aridair's drying time ranges from 25 minutes at 20 per cent relative humidity to 55 minutes at 80 per cent.

Available in two-tone pearl gray wrinkle enamel, the Aridair has a base of bonderized sheet metal. The drip tray is passivated stainless steel as is also the removable hanger rack. The drier has a capacity up to twelve 14 by 17 inch films in standard hangers. **General Electric X-Ray Corp., Dept. MH, 4855 Electric Ave., Milwaukee 14, Wis. (Key No. 23)**

Fluorescent Luminaires

The Curtis "Coronet" line is a new series of fluorescent luminaires designed to provide a practical and efficient method of obtaining high levels of quality illumination. Available for use with all four, five, six and eight foot fluorescent lamps, slimline, low-brightness or starter type, the units are durably constructed with all control equipment completely enclosed in a sturdy steel housing. Efficient side reflectors are available in either alzak processed aluminum or steel finished in baked white "Fluracite." Units are available with either 40 degree crosswise and 40 degree lengthwise shielding or 40 degree crosswise and 25 degree lengthwise shielding. **Curtis Lighting, Inc., Dept. MH, 6135 W. 65th St., Chicago 38. (Key No. 24)**

Laminated Glass Fiber Tubing

A new glass-fiber tube and pipe material, known as Glasweld, has been introduced as a replacement for critical materials. It is said to have the strength of steel and to be rust and corrosion proof. Glasweld is made of a laminated tubing in which glass fibers are bonded with resins to develop a rugged tube impervious to extreme heat, chemical action and heavy blows. **U. S. Plywood Corp., Dept. MH, 55 W. 44th St., New York 18. (Key No. 25)**

Overbed Table

The new Model 1950 overbed table has a one-piece unbroken table surface with no cracks to collect food particles or dirt. It is easy to clean and beneath it is a drawer and a concealed, sliding mirror and reading rack for the patient's convenience. Both drawer and mirror are reversible so that the table can be used from either side of the bed. The smooth turning crank for easy adjustment of the height is placed on top of the table, for easy operation by the patient.

The table top and drawers are of selected Northern Hard Birch, with all wood parts protected with Enduro, a strong, hard finish for attractive appear-

ance and easy maintenance. All load-supporting parts are of light aluminum alloy. The table is light in weight and easily maneuvered but it is strong and will support heavy loads at the extreme end of the table without tipping. **Carrom Industries, Inc., Dept. MH, Ludington, Mich. (Key No. 26)**

Water-Repellent Coating

Exterior masonry surfaces of many kinds can be protected with a new transparent water-repellent coating known as Hydropel. The new formulation of Hydropel is such that after application to a masonry or stone building rain and snow are repelled and dirt and soot are not absorbed into the surface by infiltration of moisture. It does not form a film on the surface and is completely invisible. The original texture and color of the building are retained and one treatment lasts indefinitely. **United Laboratories, Inc., Dept. MH, 16801 Euclid Ave., Cleveland 12, Ohio. (Key No. 27)**

Drum Rack

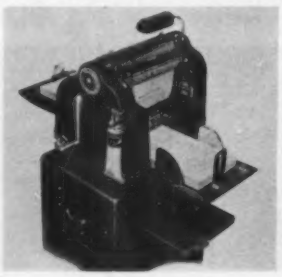
The E-Z-Lift Drum Cradle is a rack designed according to Johnson specifications, made of strong bolted one inch angle iron with a four inch drum lift plate and one and one-quarter inch supporting cross members. It will handle up to 700 pound drums and is available at a low price to Johnson drum customers. The E-Z-Lift trucks drums easily, quickly and safely and holds the spigot high enough for easy drawing into a large pail. Its wide base gives it stability and makes it difficult to tip over. **S. C. Johnson & Son, Inc., Dept. MH, Racine, Wis. (Key No. 28)**

Liquid Carbonator

A new Atomic Carbonator for soda fountains in lunch rooms and gift shops employs a new principle of instantaneous triple action carbonation. With the new carbonator a large storage tank is unnecessary since carbonation is complete in one pass through the aspirator system. The capacity of the carbonator is the capacity of the pump and motor supplying water. The new unit is small and compact, has no moving parts and is designed for trouble-free operation. **The Liquid Carbonic Corp., Dept. MH, 3100 S. Kedzie Ave., Chicago 23. (Key No. 29)**

Duplicating Machine

A new inking principle which employs paste ink packaged in a large flexible tube which is clipped into the machine and vacuum fed to the dual cylinder printing system is a feature of the Gestetner Duplicator being introduced into the United States from Britain. The machine can be used for color printing with a wide variety of colors and it reproduces illustrations from stencils prepared photographically. The Gestetner is an office duplicator for the reproduction of all types of printed matter. The American Division of the British



company is **Duplicator Corporation, Dept. MH, 80 McLean Ave., Yonkers 5, N. Y. (Key No. 30)**

Address manufacturers for further information and Prices — or use Reader's Service blank on page 222

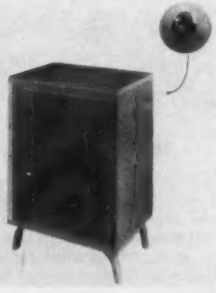
Breathing Instrument

A portable "automatic breathing instrument" for use with victims of drowning, electric shock, suffocating gases, heart attacks and other kinds of asphyxiation has recently been announced. Known as the "Pneolator," the apparatus consists of a rubber and plastic facepiece connected to two valves by two 4 foot lengths of corrugated rubber tubing. One valve administers oxygen with positive pressure at regular intervals and the other valve lets oxygen flow only when the patient inhales and stops the flow on exhalation. The valves are arranged to interchange automatically, depending upon whether or not the patient is breathing. A built-in aspirator tube is designed to remove obstructions from the throat. **Mine Safety Appliance Co., Dept. MH, 411 Seventh Ave., Pittsburgh 19, Pa. (Key No. 31)**

Bedside Chest

Designed to serve as a chest for the patient's needs as well as a bedside cabinet to save space in small rooms, the new Bedside Chest No. 822 has two extra large sized drawers for patient use, one of which is fitted with a new type lock. When the patient goes to surgery or for treatment or examination outside his room, he can put his valuables in the drawer which is locked by a push-click cylinder lock. The key is kept at the nursing station.

The cabinet is of hard wood construction with matching wood Formica top. The chest is 24 by 18 inches and in addition to the two drawers, it provides a convenient pull-out tray for the nurse's use and the lower compartment has facilities for a free swinging basin ring, metal bedpan rack, urinal holder and nurse's utility shelf. The 13 ply hardwood legs are electronically-welded and available with casters. The door hinge is of the heavy duty piano type. The chest is modern in design and attractive



in appearance. **Hospital Furniture, Inc., Dept. MH, 936 N. Michigan Ave., Chicago 11. (Key No. 32)**

Frigi-Therm Applicators

The new Frigi-Therm Hot or Cold Applicators are designed to conform comfortably to specific body areas and contours. A special corrugated molding permits complete flexibility and the sturdy walls maintain heat or cold for long periods. "Bulkheads" are built-in to provide even distribution of temperature and effective treatment is possible because the design permits great surface area contact.

Frigi-Therm Applicators are available for specific application to various parts of the anatomy. The Helmet is designed to fit over the head; the Aural Applicator fits around the ear; the Throat Applicator fits snugly around the neck; the Sinus Applicator fits over the entire sinus area, and the General Applicator can be used on any large area. In addition, there are a Water Bottle and an Ice Bag in the new line. All applicators can be sterilized by boiling and are made with screw-type stoppers. They are designed for all external application therapy

and tying anchors are incorporated to keep them in place. **American Cystoscope Makers, Inc., Dept. MH, 1241 Lafayette Ave., New York 59. (Key No. 33)**

Skin Thermometer

The Heidenwolf Skin Thermometer, accepted by hospitals and universities in Europe, is now available in the United States through Heitz Instruments. It is a diagnostic instrument based on the principle of a temperature perceiving magnet in a magnetic field. This small measuring magnet becomes more magnetic with rising temperature, influencing the recording device. No electric current or battery is needed and the device is easy to use and to carry and is designed for long life. No change in the examined part of the skin is caused by application of the Skin Thermometer. **Heitz Instruments, Inc., Dept. MH, 15 E. 26th St., New York 10. (Key No. 34)**

Sterile Transfer Forceps

The improved Bard-Parker Transfer Forceps unit is now available with either a Pyrex glass or a stainless steel jar. Both jars are slightly flared at the top to hold the rubber jar gasket firmly and prevent it slipping off, even when wet. The Pyrex glass jar may be autoclaved without danger of breakage and provides visibility of the solution level inside the jar. The stainless steel jar has a heavy base to reduce the possibility of accidental tipping.

The stainless steel forceps has been reenforced to provide greater strength without impairing its capacity for picking up even the smallest needle. The complete unit provides a practical means of handling sterile instruments and supplies in the operating room. **Bard-Parker Company, Inc., Dept. MH, Danbury, Conn. (Key No. 35)**

Intercommunicating Telephones

A new series of intercommunicating telephones is being offered over the name "Idealfones." The Type 4 "Idealfone" System consists of a compact plastic speaker cabinet for the executive's desk connected to a handset "Idealfone" for the secretary's desk. A new scientific principle is employed in the system to provide adequate speaker volume and sensitive microphone facilities for the executive's office without need for either a vacuum tube amplifier or "talk-listen" key.

Other systems in the "Idealfone" group employ compact plastic handset telephones which are adaptable to either desk or wall use and which use push-button signaling and a single metallic talking circuit. Through various combinations of single-button and six-button telephones "Idealfone" Systems, Types 1, 2 and 3, offer facilities for serving two to eight stations on a code ringing, selective ringing or master station basis. **Automatic Electric Co., Dept. MH, 1033 W. Van Buren St., Chicago 7. (Key No. 36)**

Address manufacturers for further information and Prices — or use Reader's Service blank on page 222

Handle Holder

A new handle holding device for mops, brooms and tools is available as the Hand-L-Hold. It is easily attached to any wall by two screws. The handle of the mop or broom is inserted in a movable, rubber-grooved gripper by an upward swing and is held securely by the force of its own weight. It is easily lifted out for removal. **The Bassick Co., Dept. MH, Bridgeport 2, Conn. (Key No. 37)**

Kotex Hospital Belt

Convenience to the patient and a saving to the hospital are combined in the new Kotex Hospital Belt for obstetric patients. Safer application and change of pads is said to result from the use of this belt which is satisfactory for both bed and ambulatory patients. It eliminates the need for laundering T-binders and since most hospitals charge the patient for the belts, the cost of laundering binders and the loss in handling them can often be converted into a modest profit.

The new 12 inch Kotex Pad for use with the new belt is designed to absorb the normal drainage during the usual interval between changes so that only one pad need be used instead of two or three, thus providing another saving while increasing patient comfort. **Bauer & Black, Dept. MH, 2500 S. Dearborn St., Chicago 16. (Key No. 38)**

Fluoroscopic Footswitch

A new fluoroscopic footswitch, the "Pedaflex," is designed to permit the doctor to sit before the patient or stand in front of the x-ray table in a room darkened for fluoroscopic examination and have positive independent foot control of both x-ray exposure and room light. The switch is exceptionally thin and comfortable under foot and requires only slight pressure on the platform for momentary x-ray exposure while a deliberate shift of the foot detects the raised bar for roomlight control. The fluorescent indicator in the center of the "Pedaflex" makes it easy to find the switch in the dark and helps guard against accidental x-ray exposure or switching on of the room light.

The under surface of the "Pedaflex" is corrugated to prevent creeping, even on a waxed tile or terrazzo floor. Construction of the switch is rugged and it is designed to stand the rough handling of regular use even though it is highly sensitive to the operator's foot action. The new switch can be used in combination with all makes of x-ray equipment. **Westinghouse Electric Corp., Dept. MH, 2519 Wilkens Ave., Baltimore 3, Md. (Key No. 39)**

Pharmaceuticals

Neotrizine

Neotrizine is a sulfonamide mixture composed of equal parts of sulfadiazine, sulfamerazine and sulfamethazine. It has been developed for use in sulfonamide therapy since a mixture of sulfonamides has been shown to provide additive antibacterial effectiveness while retaining independent solubility, thus resulting in less likelihood of intrarenal precipitation of the drugs.. The product is supplied in the form of tablets, Savorets or flavored tablets and in suspension. **Eli Lilly & Co., Dept. MH, Indianapolis 6, Ind. (Key No. 40)**

Terramycin

Terramycin is now available in two new forms. This wide-range antibiotic is available as Terramycin Intravenous for treatment where immediate therapeutic action is essential. It is available in two package sizes, containing either 250 mg. or 500 mg. of sterile Crystalline Terramycin Hydrochloride.

Crystalline Terramycin Hydrochloride Ointment is a smooth ointment of crystalline terramycin hydrochloride in a petrolatum base for treatment of local infections. It may be used topically or prophylactically in cases of minor surgery and minor injuries. The ointment is packaged in 1 ounce tubes. Each gram of the ointment contains the equivalent of 30 mg. of pure terramycin. **Chas. Pfizer & Co., Inc., Dept. MH, 630 Flushing, Brooklyn 6, N. Y. (Key No. 41)**

Topaminic

Topaminic is a new antihistaminic, analgesic cream for prompt relief of acute itching due to atopic and contact dermatitis and a variety of other allergic skin disorders. Topaminic combines methapyrilene hydrochloride, calamine, benzocaine and hexylated m-cresol in a bland water-washable base. It is supplied in one ounce tubes. **Sharp & Dohme, Inc., Dept. MH, 640 N. Broad St., Philadelphia 1, Pa. (Key No. 42)**

Oxsorbil Capsules

Oxsorbil Capsules are a cholagogue and hydrocholeretic which incorporates Sorbitan Monooleate Polyoxyethylene derivative which enhances the emulsification and absorption of fats and thus permits the inclusion of larger amounts of fats in the diet of the gall bladder patient to ensure more normal nutrition and more complete flushing of the biliary tract. The capsules are provided in bottles of 100. **Ives-Cameron Co., Inc., Dept. MH, 22 E. 40th St., New York 16. (Key No. 43)**

Com-Pen

Com-Pen and Com-Pen Aqueous are two new dosage forms of procaine penicillin G recently introduced by C.S.C. Pharmaceuticals. Com-Pen is crystalline procaine penicillin G for aqueous injection and Com-Pen Aqueous is crystalline procaine penicillin G in aqueous suspension. Both products are readily aspirated and injected through a 20 gauge needle. Both dosage forms are indicated whenever a repository type of penicillin is required. Com-Pen is supplied in dry powder form in five dose vials and in single dose vials in individual cartons and in hospital packages of 50. Com-Pen Aqueous is ready for injection. It is made available in 10 cc. vials, 300,000 units per cc., and in single dose vials packed in individual cartons and in hospital packages of 50. **C.S.C. Pharmaceuticals, Div. of Commercial Solvents Corp., Dept. MH, 17 E. 42nd St., New York 17. (Key No. 44)**

Pontocaine Hydrochloride

Two new forms of a heavy solution of Pontocaine Hydrochloride for spinal anesthesia have recently been introduced. They consist of a 5 cc. ampule containing 0.3 per cent Pontocaine Hydrochloride in 6 per cent dextrose solution and a 2 cc. ampule containing 0.2 per cent Pontocaine Hydrochloride in 6 per cent dextrose solution. The products are indicated for prolonged anesthesia for major surgery and for use in obstetrics. The solutions are packed in boxes of 10 ampules. **Winthrop-Stearns Inc., Dept. MH, 1450 Broadway, New York 18. (Key No. 45)**

Trimeton Maleate Solution

Trimeton Maleate Solution is a 0.5 per cent aqueous solution of Prophenpyridamine Maleate. Sodium ethylthiomercurisalicylate is added as a preservative. It is indicated for relief of ocular symptoms of an allergic or irritative origin, such as occur with hay fever. It is supplied in dropper bottles, each containing 15 cc. of Trimeton Maleate Solution 0.5 per cent. **Schering Corp., Dept. MH, Bloomfield, N.J. (Key No. 46)**

Mumps Vaccine

A preventive vaccine against mumps, which may give immunity lasting for one year following the administration of two injections, has recently been introduced. It is recommended for routine inoculation of children housed together in large groups or personnel in institutions such as hospitals. **Lederle Laboratories Div., Dept. MH, Pearl River, N. Y. (Key No. 47)**

Address manufacturers for further information and Prices — or use Reader's Service blank on page 222

Product Literature

• **"Practical Planning of the Central Sterile Supply Department"** is the subject of a 32 page booklet, fully indexed, which has been prepared by the American Sterilizer Co., Erie, Pa. The booklet is illustrated with drawings showing floor plans and layout of the central supply department as well as photographs of actual installations. Also pictured and described are plans and installations of a solution preparation room, a glove preparation room and the equipment required for efficient operation of all departments. Data on central supply planning covers five plans for hospitals ranging in size from 150 to 350 beds. **(Key No. 48)**

• A guide to correct water treatment is offered by Elgin Softener Corp., Elgin, Ill., in **Bulletin 551, "Elgin Water Treatments Specifically Formulated for Every Need."** The booklet covers the complete scope of water treatment for every need, what types of treatments are required for special problems, and covers supplementary treatments for specially treated water. **(Key No. 49)**

• Specialized materials designed to help institutional laundries turn out quality wash with greater economy are discussed in a 24 page illustrated booklet, **"Facts to Help You Turn Out Quality Wash,"** published by Oakite Products, Inc., 118A Thames St., New York 6. The importance of devoting time and study to the selection of materials so that resulting formulas remove soils completely, quickly and safely are stressed. **(Key No. 50)**

• A new catalog of **Ulmer Pharmaceuticals** has been issued by Physicians & Hospitals Supply Co., Inc., 414 S. Sixth St., Minneapolis 15, Minn. The catalog gives general information regarding Ulmer Pharmaceuticals and then gives descriptive information on each item in the line. **(Key No. 51)**

• A new catalog of **"K&J Institutional Trucks"** has just been issued by Kilbourne & Jacobs Mfg. Co., Columbus 16, Ohio. Over 80 models are described and illustrated, each engineered specifically for its particular use with special attention to the selection of wheel and bearing and tire equipment. Included are kitchen, laundry and dish trucks; maid service and mop trucks; open and closed food service trucks in enameled or stainless steel, and many highly specialized units such as hospital dressing tables and oxygen tank trucks. **(Key No. 52)**

• Four new folders have been published by The Walker China Co., Bedford, Ohio, covering porcelain dinnerware for institutional use. Printed in color, the folders describe and illustrate four popular Walker patterns: **Herald, Hardwich, Colonial and Bramble. (Key No. 53)**

• **"Roof Savers"** is the title of a folder issued by Johns-Manville, 22 E. 40th St., New York 16, giving information on how to prolong the life of a roof and how to repair accidental damage. **(Key No. 54)**

• The Standard Recordlift, a vertical lift conveyor designed to distribute mail, records, files and general supplies in institutions and other large buildings, is illustrated and described in **Bulletin No. 150** recently released by Standard Conveyor Co., Dept. MH, North St. Paul 9, Minn. Illustrations show the operation of this system where the operator places the material in a container, depresses the push button designating the proper floor, puts the container into the load-opening and goes about other duties. **(Key No. 55)**

• A booklet on **"Public Relations Problems"** has been published by the National Publicity Council for Health and Welfare Services, Inc., 257 Fourth Ave., New York 10. The 44 page, paper bound booklet sells at one dollar a copy and presents helpful information in textbook style. **(Key No. 56)**

• Books published for the nursing profession during 1950 by W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa., are listed and described in the **Saunders Nursing Catalog.** Books are grouped under subject headings and the catalog is indexed. **(Key No. 57)**

• Three booklets on equipment for artificial respiration are available from J. J. Monaghan Company, Inc., 500 Alcott, Denver 4, Colo. One booklet, Bulletin No. 5, deals with the **"Bennett Positive Pressure Attachment"** for simplified nursing care and increased patient therapy and comfort. The **"Bennett Respirator Cam"** for increased patient comfort and improved ventilation is described and illustrated in Bulletin No. 6. Detailed descriptive information on the **"Monaghan Positive Pressure Attachment"** for the Monaghan Portable Respirator is given in Bulletin No. 4. All three are illustrated with drawings or photographs to show the workings of the attachments. **(Key No. 58)**

• **"Herring-Hall-Marvin Adaptable Stock Designs in Metal Cabinetwork for Hospitals"** is the subject of a brochure recently published by Herring-Hall-Marvin Safe Co., Hamilton, Ohio. Typical examples of Herring-Hall-Marvin hospital cabinetwork are pictured and described in the folder. Specifications and drawings of various construction details common to all units are offered and general construction features of the metal cabinets, cases, counters, bases, sinks, lockers and shelving in stainless or furniture steel are given. **(Key No. 59)**

• A new two color catalog on **"Fenestra Hollow Metal Swing Door Units"** has been released by Detroit Steel Products Co., 2250 E. Grand Blvd., Detroit 11, Mich. Doors described in the new catalog include entrance doors and Underwriters' B-Label Door Units for both single and double openings. Uses, advantages, installation data, construction features, hardware and equipment are included in the catalog which also charts types and sizes. **(Key No. 60)**

• **"Without Straw"** is the title of an attractive little brochure issued by Edward Weck & Co., Inc., 135 Johnson St., Brooklyn 1, N. Y. "Published as a contribution to the Surgical Trade Industry and to those it serves," according to the inside front cover statement, the booklet expresses the 60-year philosophy of the Weck organization and gives helpful information on purchasing principles. **(Key No. 61)**

• **"A Complete Line of Quality Floor Coverings"** is the title of a brochure issued by Edward Don & Co., 2201 S. La Salle St., Chicago 16. Illustrated and described are floor mats of every variety for institutional use including rubber mats, steel mats, cocoa mats and wood mats. The use of each type of mat and matting is discussed. **(Key No. 62)**

• Complete information on **"Jalousie Windows and Doors by Ludman"** is available in a file folder type of brochure released by Ludman Corp., P. O. Box 4541, Miami, Fla. Sketches and photographs of installations are shown as are diagrammatic drawings of the windows. Complete descriptive data and specifications are also included. **(Key No. 63)**

• A **Maintenance Portfolio** on the use of its paint coating line has been issued by The Wilbur & Williams Co., Greenleaf & Leon Sts., Boston 15, Mass. Maintenance problems of equipment and buildings are analyzed and recommendations made for economical upkeep. Included is information on specialized paint coatings for resisting moisture, fire, mildew and chemicals. **(Key No. 64)**

• Full information on **Ellison Balanced Doors** is provided in the new 1951 catalog recently released by Ellison Bronze Co., Inc., Jamestown, N.Y. The 12 page booklet contains many illustrations of this modern type of entrance door as well as detail drawings and specifications. A list of users rounds out the catalog. **(Key No. 65)**

• **"Medical Instruments For Use With Radioactivity"** are discussed in a folder issued by Nuclear Instrument & Chemical Corp., 223 W. Erie St., Chicago 10. The leaflet covers both diagnostic application and therapy. **(Key No. 66)**

Address manufacturers for further information and Prices — or use Reader's Service blank on page 222

• A comprehensive paper-bound 61-page booklet has been issued by Armour Laboratories, 520 N. Michigan Ave., Chicago 11, covering **"General Principles to be Considered and Directions for Using ACTH (Armour)." (Key No. 67)**

• Frigidaire Multiple Unit Air Conditioning equipment is discussed in a booklet, **"Air Condition Any Building In Town,"** recently published by Frigidaire Div., General Motors Corp., Dayton 1, Ohio. The advantages of air conditioning, how any sized building can be air conditioned quickly and economically and data on various phases of air conditioning and the types of buildings which have installed this system are subjects covered in the booklet. **(Key No. 68)**

• A new **catalog No. 1069,** has been issued by Ohio Chemical and Surgical Equipment Co., 1400 E. Washington Ave., Madison 10, Wis., covering **Scanlan-Morris Steril Brite Surgical Furniture.** Detailed descriptive information on this lightweight, strong and permanently lustrous furniture is given on the many items available in the line and each is attractively illustrated. **(Key No. 69)**

• A revised edition of the two-color folder describing and illustrating **Governor Clinton Safedge tumblers** for institutional use is now available from Libbey Glass, Toledo 1, Ohio. **(Key No. 70)**

Book Announcements

Clarence W. Dunham, Associate Professor of Civil Engineering, Yale University, "Foundations of Structures," how to plan and design safe, economical foundations for structures, 669 pp., $7.50. **McGraw-Hill Book Co., Inc., Dept. MH, 330 W. 42nd St., New York 18. (Key No. 71)**

Suppliers' Plant News

Bobst Pharmacal Co., Inc., 305 E. 47th St., New York 17, is a new pharmaceutical concern said to be the first to specialize in the production and distribution of ethical drugs developed especially to meet the health problems of the aged and aging. West Coast offices have been opened by the new company at **305 N. Bedford, Beverly Hills, Calif. E. Walton Bobst,** son of **Elmer H. Bobst,** president of Warner-Hudnut, Inc., is president of the new company.

Debs Hospital Supplies, Inc., 118 S. Clinton St., Chicago 6, has been appointed exclusive distributor in the hospital field for Furmoto Non Slip Floor Cream. This English polish for easy, economical floor care, with safety features, is available in two types for all kinds of floors.

Pabco Products, Inc., 475 Brannan St., San Francisco 19, Calif., is the new name of the company formerly known as **The Paraffine Companies, Inc.,** manufacturer of paints and floor coverings.

Royal Metal Manufacturing Co., 175 N. Michigan Ave., Chicago 1, manufacturer of metal furniture, announces the election of **Hobart A. Green** as president of the company. **Joseph K. Salomon** has been elected president of the two Royal Metal subsidiaries on the West Coast.

The Seamless Rubber Co., New Haven 3, Conn., manufacturer and distributor of rubber sundries, announces the appointment of **Arthur R. Gow** as **Executive Vice President and General Manager** of the company.

Wyandotte Chemicals Corp., Wyandotte, Mich., announces, effective January 1, the retirement of **Harry A. Rightmire** and the appointment of **Fred M. King** as Market Development Manager of Food, Beverage and Special Detergents for the company. Mr. Rightmire, for many years head of this department, has been active in Hospital Industries Association and in manufacturers associations in other fields. He will continue temporarily with Wyandotte in a consulting capacity and on special assignments.

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it. If you read the hospital copy or the administrator's copy of The MODERN HOSPITAL or for any other reason do not wish to clip the magazine itself, upon request we shall be glad to send you regularly a reprint of this department containing the coupon.

Bessie Covert
Editor, "What's New for Hospitals"

- ☐ 1 Liter-Flow Adaptor
- ☐ 2 Fireproof Paint Remover
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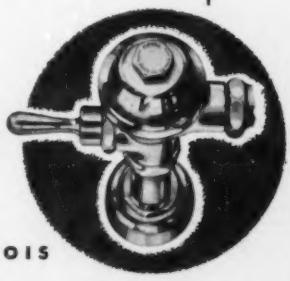

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